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# Provider Electronic Solutions User Guide

Georgia Medicaid Management Information System  
Fiscal Agent Services Project

Version 1.4



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# 1 Introducing Provider Electronic Solutions

Thank you for using HP Enterprise Services' Provider Electronic Solutions (PES). This software supports the processing of Health Insurance Portability and Accountability Act (HIPAA) ready transactions.

The HIPAA ready forms available for billing Georgia Medicaid include the following: 837 Dental, 837 Institutional Inpatient/Outpatient, 837 Institutional Nursing Facility, and 837 Professional.

Provider Electronic Solutions is available at no charge to Georgia Medicaid providers. This user manual is designed to augment the help feature located inside the Provider Electronic Solutions software. It also provides installation procedures and a contact number for the HP Enterprise Services Electronic Data Interchange (EDI) services team, whose commitment is to assist Georgia Medicaid providers with electronic claims submission.

Chapter 1, Introducing Provider Electronic Solutions, is comprised of three sections:

1. What You Need to Know to Use Provider Electronic Solutions provides definitions for important electronic claims submission terminology.
2. How to Use this Manual, describes the contents of the user manual.
3. Where to Get Help, provides a contact list for the EDI Services team and other HP Enterprise Services personnel who can assist you with claims-related questions.

**Note:** Providers should review *the Georgia Medicaid Provider General Handbook*, plus the appropriate Georgia Medicaid Coverage & Limitations Handbook, along with the Georgia Medicaid Reimbursement Handbook, for program-specific and claims filing instructions. For instance, the *Provider Electronic Solutions User Manual* will not provide instructions on which member aid categories allow for full Medicaid coverage, or inform you whether a particular procedure code requires prior authorization. Refer to the Georgia Medicaid billing and policy manuals for this information. If you do not have a current a copy of the Georgia Medicaid billing or policy manuals, please download the appropriate copy from the Georgia Medicaid homepage at [www.mmis.georgia.gov](http://www.mmis.georgia.gov).

## 1.1 What You Need to Know to Use Provider Electronic Solutions

Below are some terms and concepts that will enhance your ability to use *Provider Electronic Solutions*:

## 1.2 Submitting through Batch

Batch submission refers to sending groups of claims to HP Enterprise Services. A batch may contain one claim or many claims. These transactions are sent to the HP Enterprise Services system via our public-internet Web site. HP Enterprise Services processes the batches of transactions and returns a



response to the Web site. Providers may retrieve their responses through the Provider Electronic Solutions application.

All claim types are available for batch transmission.

### 1.3 Internet Access

Since Provider Electronic Solutions submits batch transactions through the public internet, your personal computer (PC) must have a method of connecting to the Web. An internet service provider (ISP) can provide this connection through a dial-up modem, DSL, or a cable link. HP Enterprise Services provides a Remote Access Server (RAS) for providers who do not have a method of connecting to the internet to gain access to the HP Enterprise Services Web site via PES for claims submission. Your computer can dial into the RAS using a modem. If you live outside the Atlanta calling area, you must be able to place a long distance call over the phone line. An internet browser will also be required to maintain your security ID and password. The HP Enterprise Services software is written to work best using the Internet Explorer (IE) browser.

### 1.4 Using a Modem

Your modem may be part of your PC, or attached to your PC. Regardless, it must also be attached to a working phone line. If you plan to submit batch transactions and you live outside the Atlanta calling area, you must be able to place a long distance call over the phone line. Setting Up Personal Options, describes how to set up Provider Electronic Solutions with your modem information.

### 1.5 Provider Electronic Solutions Procedures Manual versus the Georgia Medicaid Provider Manual

This procedures manual describes: how to install and set up Provider Electronic Solutions, how to navigate in Provider Electronic Solutions, how to establish lists to suit your business needs, how to complete the required and optional fields on the electronic forms, how to submit transactions, and how to produce reports. It does not provide program-specific billing information. The user manual describes how to complete the electronic claim forms correctly to enable you to submit claims that pay correctly.

**Note:** The Provider Electronic Solutions software requires that you have a submitter ID in order to submit electronic claims to Georgia Medicaid. If you have used the software previously, this information can be found by opening the software and going to Tools >> Options >> Batch Tab. If you have never used the HP Enterprise Services software and need a submitter ID, please call 866-261-8785. You will not be able to use Provider Electronic Solutions to submit batch without this information.



## 1.6 Where to get Help

Provider Electronic Solutions features extensive, field-level help which is available by pressing <F1> while working within the software. Certain windows feature a Help button which accesses field level help. Field level help means that you can position your cursor in a field you are unfamiliar with, press <F1> or the Help button, if applicable, and read the online help to determine the usage of that field. Also, HP Enterprise Services provides a user manual on CD-ROM to ensure access to as much information as possible about Provider Electronic Solutions.

If you still have questions, or if you encounter difficulty using Provider Electronic Solutions or dialing into the HP Enterprise Services system, contact the EDI Services team at 866-261-8785. The EDI services team staff is available from 8:00 a.m. EST to 12:00p.m. EST and 1:00p.m. EST to 5:00 p.m. EST Monday through Friday, excluding holidays.



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## 2 Installing HIPAA Provider Electronic Solutions

This chapter covers equipment requirements, instructions on obtaining a copy of Provider Electronic Solutions, installation procedures, setting up personal options, installing software upgrades, and other maintenance options such as archiving and database recovery.

### 2.1 Equipment Requirements

Before installing *Provider Electronic Solutions*, you must ensure that your PC has at least the minimum requirements listed below.

Minimum	Recommended
Internet Explorer Version 5.5 or Netscape Browser Version 6.1	Internet Explorer Version 6.0 or Netscape Browser Version 7.1
Pentium II	Pentium III
** Windows 98/2000/XP	Windows XP
64 Megabytes RAM	128 Megabytes RAM
800 x 600 Resolution	1024 x 768 Resolution
28.8 Baud Rate modem (required only for dial-up transmission)	56K Baud Rate modem (only for dial-up transmission)

\*\* Windows 98 is the minimum platform, but it is no longer supported by Microsoft.

### 2.2 Getting a Copy of Provider Electronic Solutions

You can receive a copy of the software in several media. Use the table below to determine the best media for you.

Media	How to Get it
CD-ROM	Contact the EDI Services team at 866-261-8785. HP Enterprise Services will send you one CD-ROM with accompanying documentation.
ZIPTM file	Download from the Georgia Medicaid Web site at: <a href="http://www.mmis.georgia.gov">www.mmis.georgia.gov</a> . Please note that the downloading process may take a considerable amount of time due to the size of the application file.

When you receive CD-ROM, store it in a safe place should you need to reinstall at a later date.



## 2.3 Installation Procedures

Updated versions of the software contain enhancements to the application. These updated releases may be downloaded from the Georgia Medicaid Web site at [www.mmis.georgia.gov](http://www.mmis.georgia.gov). See Installing Software Updates, for more information.

The installation procedures vary slightly depending on the way you received the software (CD/ROM or ZIP file, as described above). This section describes installation procedures from CD, and installation procedures from a ZIP file (downloaded from the Web).

## 2.4 Installing from CD

**Note:** Exit all other Windows programs before running the setup program. This includes MS Word, e-mail systems, or other applications.

This section provides step-by-step instructions for installing Provider Electronic Solutions on a PC running at least Windows 2000.

When you install the software from a CD, the auto installation program begins the process for you. Insert the CD in your CD drive. The Set up box displays on your desktop after a few moments. The HP Enterprise Services Provider Electronic Solutions Welcome screen then displays.

1. The HP Enterprise Services Provider Electronic Solutions Setup program will initialize. Please wait a few moments while this occurs. The Setup Screen Welcome window displays.
2. Click 'Next' after reviewing the text on the window.
3. The setup window should now be displayed.

**Note:** Typical - Installs all the files, including the database. This installation is used to install the software to a stand-alone PC

1. Click 'Next' to continue. Then, Choose Destination Location window displays.
2. Click 'Next' to choose the default destination folder (recommended) or click Browse to select another destination folder. Then click 'Next' to advance the setup program. The following message displays:
3. Please note the database destination folder for future WORKSTATION setups.
4. Click 'OK' to access the Setup Complete window. Click 'Finish' to complete setup.
5. The setup program creates an icon on your desktop for GA HP Enterprise Services Provider Electronic Solutions. To access the application, double-click on the icon. The GA HP Enterprise Services Provider Electronic Solutions window displays.



## 2.5 Installing from a ZIP File

**Note:** Exit all other Windows programs before running the setup program. This includes MS Word, e-mail systems, or other applications. These instructions assume you are familiar with your Web browser and have used it to access the Internet to download information.

Access the Georgia Medicaid homepage at the following address: [www.mmis.georgia.gov](http://www.mmis.georgia.gov)

1. Click on the 'Public Information for Providers' link then the 'EDI' link. The Georgia Medicaid Provider Software page displays.
2. Click on the Provider Electronic Solutions Software link. The Provider Electronic Solutions Software Specifications page displays.
3. Review the information on the page. Use the scroll bar to move down the page, until you see the Provider Electronic Solutions Full Install.
4. Your browser may ask you if you want to open the application or save it to disk. Choose "Save it to Disk" then click on 'OK' button to choose a directory on your hard drive. Please note this application is too large to fit on a 3.5" diskette. If you choose not to save it to your hard drive, you must have a ZIP drive, CD-ROM Write-Once-Read-Many (WORM) recorder, or some other method for saving large files.
5. Wait while the ZIP file downloads. The download time varies depending on your Internet connection, your PC's processing speed, and other factors. When the download is complete, access the ZIP file through Windows Explorer or File Manager if your download screen closes and continue to step 6.
6. After the download has completed, the download box will ask if you wish to OPEN, OPEN FOLDER, or CLOSE. Choose 'OPEN'. A new box will appear.
7. Click NEXT after reviewing the text in the window.
8. Choose the default setup type (Typical). **Note:** Typical - Installs all the files, including the database. This installation is used to install the software to a stand-alone PC.
9. Click 'Next' to choose the default destination folder (recommended) or click Browse to select another destination folder. Then click 'Next' to advance the setup program. The following message displays: Please note the database destination folder for future WORKSTATION setups.
10. Click 'OK' to access the Setup Complete window. Click 'Finish' to complete setup.



## 2.6 Accessing the Application

To access the application, perform the following steps:

1. Double click the application folder from the desktop and then select GA HP Enterprise Services Provider Electronic Solutions or select the Start button on the bottom left-hand corner of your screen, then go to Programs and select GA HP Enterprise Services Provider Electronic Solutions.

The image shows a Windows-style dialog box titled "hp Logon". On the left is the HP logo. The main text reads: "Enter a User ID and password to log onto the HP Provider Electronic Solutions Application." Below this are two input fields: "User ID" with the text "pes-admin" and "Password" which is empty. To the right of the fields are two buttons: "OK" and "Cancel".

2. Once the Logon Screen appears enter the default user password which is: **hp-pes**. The default user ID should remain as: pes-admin. Click OK.

The image shows a Windows-style dialog box titled "hp Logon". On the left is the HP logo. The main text reads: "Enter all fields to change a user password on the HP Provider Electronic Solutions Application." Below this are several input fields: "User ID" (containing "pes-admin"), "Old Password", "New Password", "Rekey New Password", "Question" (a dropdown menu), "Answer", and "Rekey Answer". To the right of the fields are two buttons: "OK" and "Cancel".

3. The first time you log on, a Password Expired Box will appear, click 'OK'.
4. The Logon Screen will prompt you to change your password. Fill in the information as stated below:
  - a. Type the old password, HP Enterprise Services-PES in the Old Password field.
  - b. Type your new password in the New Password field. Your new password must be a minimum of five and a maximum of ten alphanumeric characters. PLEASE STORE YOUR NEW PASSWORD IN A SAFE PLACE IN CASE IT IS FORGOTTEN.
  - c. Retype your new password in the Rekey New Password field.



- d. Choose a question as your security question in the event you lose or misplace your new password.
  - e. Enter and re-enter the answer to your security question in the designated fields. Click 'OK' to continue.
5. The Logon Status Box will appear, indicating that your password was successfully updated. Click 'OK'.

## 2.7 Changing Password

There may be times when you feel a need to change your password. The Change Password option is designed to allow you to do so. The password is defaulted to prompt its user to change the password every ninety days. This option may be adjusted, review Section 2.4 Retention Tab to do so.

1. Go to Tools >> Change Password
2. Enter your old password in the **Old Password** field.
3. Enter your new password in the **New Password** field.
4. Re-enter your new password in the **Rekey New Password** field.
5. Choose a security question, in the event you lose or misplace your password.
6. Enter and re-enter the answer to your security question in the designated fields.
7. Click OK to save your new Provider Electronic Solutions password.

## 2.8 Security Maintenance

There is an option to add users to access the Provider Electronic Solutions software without having to use the same logon ID. This also establishes certain users to have administrator versus non-administrator rights. This option may be accessed by going to Security >> Security Maintenance. Follow the steps below to add additional users to the Provider Electronic Solutions application.

### **Adding New Users**

1. Go to Security >> Security Maintenance to access the screen. You must be logged on as an administrator to complete this process. The default administrator ID is pes-admin.
2. Enter a new User ID in the User ID field.
3. Enter the new user's password in the Password field.



4. Choose the new user's authorization level.
  - a. User (Non-administrator) – This option allows the user to access the Provider Electronic Solutions software, create and save claims, submit electronic transactions and make the needed adjustments to the personal options menu. (This option only restricts users from adding or removing additional users.)
  - b. Administrator – This option allows the user to access the Provider Electronic Solutions software, create and save claims, submit electronic transactions, adjust their personal options, and create new users.
5. Click on 'Save' once you have completed the above steps. Click on 'Close' to close the Security Maintenance screen.
6. Once the new user logs on, they will be prompted to create a new password. Refer to Section 2.4 *Setting Up Personal Options*.

**Note:** Store your new user ID and password in a safe location for future use. If your password is lost or misplaced, have your administrator logon as pes-admin to assign your ID a new password.

### Removing Users

1. Go to Security >> Security Maintenance to access the screen. (You must be logged on as an administrator to complete this process. The default administrator ID is pes-admin.)
2. Choose the user ID you wish to remove by clicking on it.
3. Once highlighted, the information will auto-write into the fields.
4. Click on 'Delete' to remove the user.
5. Click on 'Close' once you have completed this process for each user you wanted to remove.

## 2.9 Setting Up Personal Options

**Note:** The *Provider Electronic Solutions* software requires that you have a submitter ID in order to submit electronic claims to Georgia Medicaid. If you have used the software previously, this information can be found by opening the software and going to Tools >> Options >> Batch Tab. If you have never used the HP Enterprise Services software and need a submitter ID, please call 866-261-8785. **You will not be able to use *Provider Electronic Solutions* to submit batch without this information.**

To use *Provider Electronic Solutions*, you must set up your personal options, including the following:

1. If not connected through an ISP you must make modifications to install the RAS dial-up connection



2. Logon IDs and passwords, as provided to you by the EDI services team.
3. When you access the Provider Electronic Solutions for the first time, the following message displays:



4. Click 'OK' to access the Options window. You can also access this window by selecting Tools>>Options from the menu bar at the top of the Provider Electronic Solutions application window.

The Options window contains four tabs and four main buttons. These are described below:

### Tabs

Tab	Usage
Batch	Use this tab to set up a trading partner ID, Web logon ID, password to log on to the Medicaid Web site, and the requester's contact information.
Connection	Use this tab to configure how to connect to the Medicaid Web site for claim submission.
Payer/Processor	Use this tab to access your system's payer/processor information.
Retention	Use this tab to establish retention settings for archive days, batch information, verification information, logs, and password expiration.

### Buttons

Button	Usage
Help	Use this button to access the online help for the field currently being accessed.
Print	Use this button to print options selected for all of the tabs.
OK	Use this button to save and close the information added or modified.
Close	Use this button to close the Options window.



## 2.9.1 Connection Tab

Users access the Web tab to modify their method of connection to the Medicaid Submission site. A sample Options window displaying the Web tab is pictured below:

Field	Guidelines
HTTP Port	To obtain the HTTP Port of your proxy server right-click on the Internet Explorer icon and left-click on properties. Click on the Connections tab and enter the LAN Settings. Click on Advanced and review the Port information for HTTP. <b>Note:</b> This may not work in all networked environments.
HTTPS Port	To obtain the HTTPS Port, follow the instructions above under HTTP Port and enter the Secure port number in this field. <b>Note:</b> This may not work in all networked environments.
Proxy Bypass	The Proxy Bypass information is found on the same window as the HTTP and HTTPS ports in the Exceptions text area. <b>Note:</b> This may not work in all networked environments.
Environment Ind	Indicate if the submission is Production or Test. Remember, if you have your indicator as Test your claims will not be paid.
RAS Phone #	If you use a dialup modem, enter 8778484989. If your phone service requires additional dialing features you may adjust this number to add those features. Such as dialing a '9' to get an outside line and '1' for long distance would be entered as: 9, 18778484989.
Install RAS	If you choose to use a dial-up modem to connect to Medicaid, you must choose a Dialup Network option provided. If you have no option provided, press the Install RAS button and the option GA RAS will be available to you. <b>Note:</b> Due to a delay in installing RAS, the user may have to click on the 'LAN' option and



Field	Guidelines
	then back to the 'Modem' option for the RAS Dial-up Network to display.
HTTP Port	To obtain the HTTP Port of your proxy server right-click on the Internet Explorer icon and left-click on properties. Click on the Connections tab and enter the LAN Settings. Click on Advanced and review the Port information for HTTP. <b>Note:</b> This may not work in all networked environments.
HTTPS Port	To obtain the HTTPS Port, follow the instructions above under HTTP Port and enter the Secure port number in this field. <b>Note:</b> This may not work in all networked environments.

### 2.9.2 Batch Tab

Users access the Batch tab to enter a trading partner ID, Web logon ID, password, and the requesters contact information. A sample Options window displaying the Batch tab is pictured below:

The screenshot shows a software window titled "hp Options". It has four tabs: "Connection", "Batch", "Payer/Processor", and "Retention". The "Batch" tab is selected. Inside the "Batch" tab, there are several input fields: "Web Logon ID" and "Web Password" (both text boxes), "Entity Type Qualifier" (a dropdown menu), "Last/Org Name" (a text box), "First Name" (a text box), "Contact Phone #" (a text box), and "Trading Partner ID" (a text box). To the right of these fields, there are four buttons stacked vertically: "Help", "Print", "OK", and "Close".

Field	Guidelines
Use Microsoft IE Pre-config Settings	If checked, the pre-config settings within your Internet Explorer will be accessed to connect to the batch submission Web site.
Connection Type	If the Internet Explorer Pre-config Settings option is <b>not</b> checked, you must choose either LAN or Modem to identify how the PC connects to the Internet.
Use Proxy Server	If the Internet Explorer Pre-config Settings option is <b>not</b> checked and your Internet access is filtered through a Proxy Server check this setting.



Field	Guidelines
Dialup Network	If you choose the Modem Connection Type, you must select one of the Dialup Networks from the drop-down box. If you do not have an option listed, follow the instructions for the Install Remote Access Server (RAS) button.
Proxy Information – Address	To obtain the address of your proxy server right-click on the Internet Explorer icon and left-click on properties. Click on the Connections tab and enter the LAN Settings to obtain the proxy address. <b>Note:</b> This may not work in all networked environments.
Web Logon ID	Enter your Web Logon ID. If you are a first time user of the secure Web portal, you will need to set-up your Web Logon ID and password. A PIN letter from HP Enterprise Services is required in order to get started. If you have not received a PIN letter, please call the HP Enterprise Services Provider Contact Center at 800 766-4456, available 7am – 6pm, Monday through Friday.
Web Password	Enter your Web Logon Password. If you are a first time user of the secure Web portal, you will need to set-up your Web Logon ID and password. A PIN letter from HP Enterprise Services is required in order to get started. If you have not received a PIN letter, please call the HP Enterprise Services Provider Contact Center at 800 766-4456, available 7am – 6pm, Monday through Friday.
Entity Type Qualifier	Choose the best value to indicate if the Trading Partner ID is associated with a person (qualifier 1) or non-person (qualifier 2).
Last/Org Name	If the Trading Partner is a person, enter the last name. If the Trading Partner is a non person, enter the organizations name.
First Name	If the Trading Partner is a person, enter the first name.
Contact Phone #	Enter the phone number of the Trading Partner. Only numerical characters are allowed. (no dashes, no periods.)
Trading Partner ID	If you have a valid Georgia Medicaid Trading Partner ID, continue using the same ID. If you need a new Trading Partner ID contact the EDI Helpdesk at 866-261-8785.

### 2.9.3 Payer/Processor Tab

This tab contains your system's payer/processor information. The fields on this screen will populate automatically and should not be altered unless directed by HP Enterprise Services. A sample Options window displaying the Payer/Processor tab is pictured below:



The screenshot shows the 'Options' window with the 'Payer/Processor' tab selected. The window has a title bar with the HP logo and a close button. Below the title bar are four tabs: 'Connection', 'Batch', 'Payer/Processor', and 'Retention'. The 'Payer/Processor' tab is active, displaying the following fields: 'Name' with the value 'GEORGIA HEALTH PARTNERSHIP', 'Payer ID' with the value '77034', and 'Identifier Code Qualifier' with a dropdown menu showing 'PI'. On the right side of the window, there are four buttons: 'Help', 'Print', 'OK', and 'Close'.

#### 2.9.4 Retention Tab

Users access the Retention tab to establish retention settings for archive days, batch information, verification information, logs, and password expiration. A sample Options window displaying the Retention tab is pictured below:

Retention settings indicate the number of day's worth of data the software should save. Users may set retention settings as required, or may retain the default settings. Click OK to save the information.

**Note:** Increasing the retention settings results in more data saved to your hard drive. Provider Electronic Solutions enables you to archive most types of data generated by the system. There may be a better alternative to increasing your retention settings. For more information, refer to Section 12.2, Other Maintenance Options.

The screenshot shows the 'Options' window with the 'Retention' tab selected. The window has a title bar with the HP logo and a close button. Below the title bar are four tabs: 'Connection', 'Batch', 'Payer/Processor', and 'Retention'. The 'Retention' tab is active, displaying the following settings: 'Archive Days' (30), 'Max Batch' (10), 'Max Verify' (25), 'Max Log' (10), 'Max Submit Reports' (30), and 'Password Expiration Days' (30). Each setting is represented by a label and a spin box. On the right side of the window, there are four buttons: 'Help', 'Print', 'OK', and 'Close'.



## 2.10 Installing Software Updates

Occasionally, HP Enterprise Services will release updates to Provider Electronic Solutions. Upgrading your software is quick and easy with the Get Upgrades option, available from the Tools menu option.

### Receiving Notification of Upgrades

HP Enterprise Services notifies providers of PES software updates in two ways:

1. Update notices in the Georgia Medicaid Bulletin
2. Remittance and Web portal messages on the remittance advice and Web portal, respectively.

You may also elect to use the Get Upgrades option if you unexpectedly experience difficulty in submitting claims, or if you have not used the software for an extended period of time. In this manner, you can be certain you are using the most current version of Provider Electronic Solutions even if you have not received an upgrade notification.

### Upgrading Provider Electronic Solutions

Perform the following tasks to upgrade your Provider Electronic Solutions software:

1. Select Tools>>Get Upgrades from the menu bar. Depending on the Web connection options you have selected, *Provider Electronic Solutions* connects to the network and returns one of two actions:
  - a. If an upgrade is available, the system automatically downloads the upgrade to your PC. Proceed to Step 2.
  - b. If no upgrade is available, the system displays the message *No upgrades available to apply*. No further action is necessary.
2. Close *Provider Electronic Solutions*. Access the Provider Electronic Solutions folder on your desktop and click on the Upgrade icon to install the upgrade to the application.

**Note:** Providers are strongly encouraged to exit all other Windows programs before running the upgrade setup program. This includes MS Word, e-mail systems, or other applications.

Be sure to close *Provider Electronic Solutions*. Save any data currently being accessed on *Provider Electronic Solutions*, such as claims, lists, or eligibility verification responses before performing an upgrade on your software.



## 3 Navigating the Software

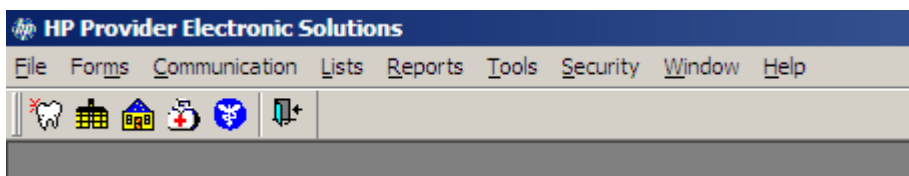
This chapter describes general navigation concepts and provides an overview of the online help feature.

### 3.1 Navigating in Provider Electronic Solutions

Before you begin using Provider Electronic Solutions, review the following section and learn how to navigate through the application with your keyboard and mouse.

Navigating through Provider Electronic Solutions is similar to other Windows-compatible applications. The navigation options available are menus, toolbars, and command buttons. Your mouse and keyboard enable you to access these navigation options. Use your mouse to point-and-click as a method for navigating through Provider Electronic Solutions.

Below are samples of the menu and icon toolbars that display on the Provider Electronic Solutions main window:



This section describes the menu and icon options available with *Provider Electronic Solutions*.

#### 3.1.1 Menus

Provider Electronic Solutions uses menus to navigate throughout the application. The menu options change depending on what window you access. When you open Provider Electronic Solutions the main menu displays.

You can access items on a menu using the mouse and clicking on icons. See below, for a listing of main menu icons. The following options are accessible from the main menu:







This menu option	Allows you to...
File	Exit from the application.
Forms	Select the online form that you wish to work with.
Communication	Submit batches of forms and process batch responses. Resubmit batches of forms. View Communication Log files.
Lists	Add and edit reference lists, which allow you to collect information to be autoplugged in online forms.
Reports	Print summary or detail reports with information from forms or reference lists.



<b>This menu option</b>	<b>Allows you to...</b>
Tools	Create and work with archives, perform database maintenance, retrieve upgrades, and change your options. The Options selection allows you to set up communications options and determine retention settings.
Security	Add, delete, and restrict users other than the administrator.
Window	Standard options available for most Windows compatible applications.
Help	Obtain help about <i>Provider Electronic Solutions</i> functions, screens, menus, and fields. Also view information about this application such as version and copyright.

### 3.1.2 Icons


















The Icons toolbar displays below the menu bar on the main menu. The twelve icons displayed are:

 837 Dental	 837 Institutional Outpatient
 837 Institutional Inpatient	 837 Professional
 837 Institutional Nursing Home	 Exit

Users can position the cursor over an icon to display a brief description.



When a form is opened, the toolbar display will change. After opening a specified form from the icon list above, the sixteen icons now displayed are:

	(Add) saves the existing form and calls up a new blank form.
	(Find) allows you to search for a claim by recipient ID, last name, first name, and billed amount.
	(Sort) allows you to sort the claims that are displayed at the bottom of the form screen by recipient ID, last name, first name, billed amount, status and submit date.
	(Errors) allows you to view errors that have been detected on the current form.
	(Calculator) calls up the calculator.
	(Exit) allows you to exit the application.
	(Add) saves the existing form and calls up a new blank form.
	(Copy) makes a copy of the existing form.
	(Delete) deletes the existing form.
	(Undo) reverses all of the changes done to the existing form since the form was last saved.
	(Save) saves the existing form.
	(Send) sends the current form.
	(Print) can only be accessed from one of the various form screens. Selecting the print button will automatically create a report and allow you to print the report that was automatically created.
	(Cut) deletes the highlighted data and places a copy of the data on the clipboard so that it can be pasted into another field or software program.
	(Copy) copies the highlighted data to the clipboard so that it can be pasted into another field or software program.
	(Paste) inserts data from the clipboard to the selected data fields or another software program.
	(Filter) allows you to define which forms are displayed at the bottom of the form screen by status, date submitted, name, amount billed, and so on.

### 3.1.3 Command Keys

Like most Windows applications, Provider Electronic Solutions provides the user with command keys. This enables the user to perform actions using either the mouse (point-and-click) or the keyboard. This section describes them.



The table below describes some standard navigation keys available with Provider Electronic Solutions:

<b>To do this...</b>	<b>Press this key...</b>
Go to the next field	<Tab> or <Enter>
Go to the previous field	<Shift>+<Tab>
Move backward within a field	Left Arrow
Move forward within a field	Right Arrow
Scroll up through a list	Up Arrow
Scroll down through a list	Down Arrow
Open online help for a field when the cursor is on a data entry field	<F1>

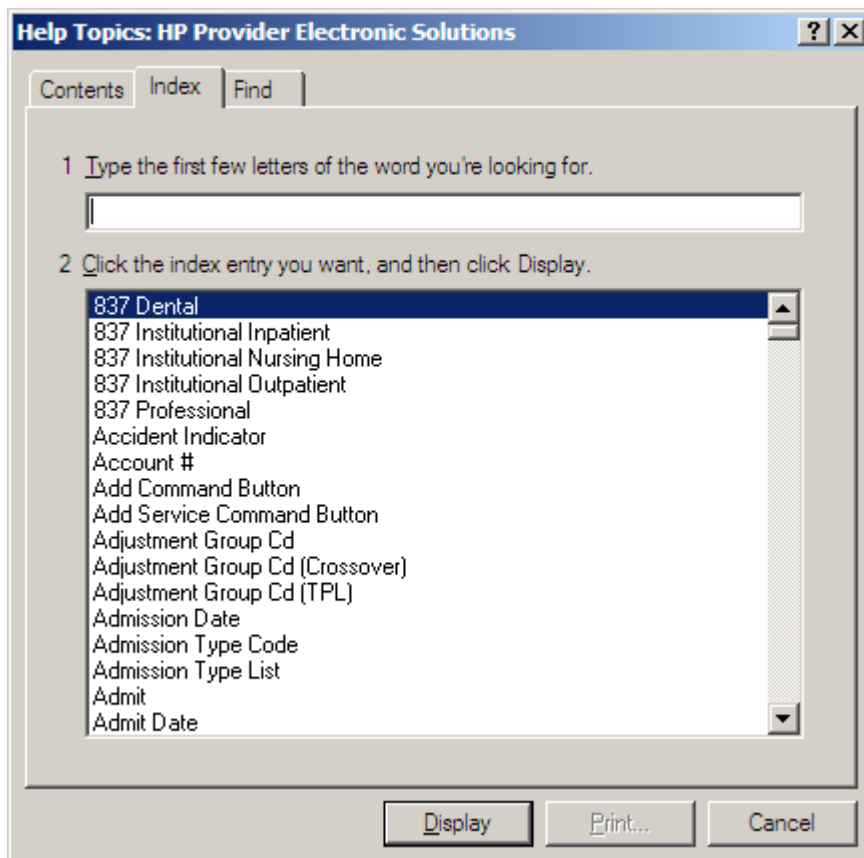
The list above includes function keys (usually located at the top of the keyboard and numbered 'F1' through 'F12'), command keys (such as <Alt>, <Shift>, <Tab>, <Ctrl>, and <Enter>), and arrow keys. Depending on your keyboard, the arrow keys may be located on the numeric keypad, or in a separate section from the numeric keypad.

To use arrow keys on the numeric keypad, you will probably press the 'Num Lock' key. Press the 'Num Lock' key again to disable the arrow keys on the numeric keypad, making them display numbers instead.

## 3.2 Getting Help

Accompanying the Provider Electronic Solutions software is context-sensitive, field-level help. Context-sensitive and field-level refer to how the help is programmed. You can access help for any field in Provider Electronic Solutions simply by positioning your cursor in the field and pressing the <F1> function key usually located at the top of your keyboard.

You can also access the help document and search on specific information by selecting the Help menu option. To access the help window, select Help>>Contents and Index>>Index. The following pop-up window displays:



Enter keywords in the Help Topics window and press <Display> to view information, or double click on topic name to view the information.

You can search by contents, by index (alphabetized), or by using the Find feature. Once you locate a specific topic, you can read the topic, or print it, and then close the pop-up window.

To return to the list of topics once you've viewed information, click the Help Topics button.

**Note:** The online help is not a substitute for the Georgia Medicaid Provider Handbooks. It merely provides general help regarding required fields and Provider Electronic Solutions functionality. It does not provide program-specific information. If you did not receive a copy of the appropriate Georgia Medicaid Provider Handbook, download a copy from the Georgia Medicaid homepage at [www.mmis.georgia.gov](http://www.mmis.georgia.gov).



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## 4 Customizing Provider Electronic Solutions

Provider Electronic Solutions contains reference lists of information that you commonly use when you enter and edit forms. For example, you can enter lists of common diagnosis codes, provider numbers, or patient IDs. After saving the list information, the lists are available as a drop-down list where you can select data to speed the data entry process and help ensure the accuracy of the form. Building a list can also increase your ability to submit correct claims quickly and efficiently.

### 4.1 Using Lists

The lists you maintain can speed up your claims filing process. When you are submitting a claim form and you access a field that corresponds to a list (for instance, the Member ID field), the system displays a drop-down menu. This drop-down list contains the records you have previously added to the list. Scroll through the records and select one. Tab through the field and the system populates the field (and any corresponding fields, such as Member Name) with the information from the list record.

Alternatively, you can double-click in any field that corresponds to a list to access the list window. From this window, you may search for a record, modify an existing record, or add a new record.

**Note:** The system does not verify the accuracy of the data you maintain on lists, other than requiring data to be the correct field length, if applicable. If you key errors in your list file (for instance, if you transpose digits for a member ID), you may not know you have made an error until you submit the claim and the claim is rejected. If you use lists, please print and review the lists occasionally to ensure their accuracy.

### 4.2 Building Lists

This chapter describes two ways to build lists with Provider Electronic Solutions and how to use lists when filing claims.

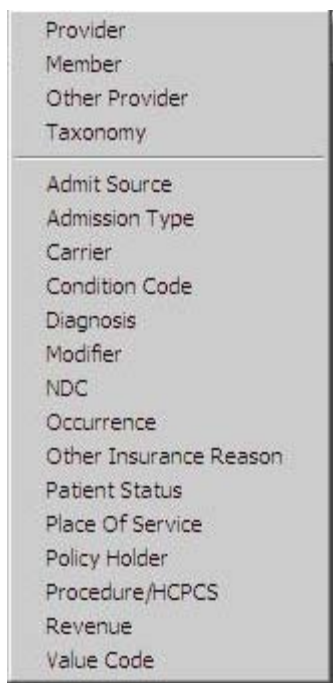
1. Accessing list windows through the List menu
2. Double clicking on certain fields while you are completing a claim form or entering an eligibility verification transaction. Double clicking on these fields accesses the corresponding list window.

With Provider Electronic Solutions, you have the option of building lists as a separate task, or building (adding) to them as you submit claims.

**Note:** To access a list window from a claim form, double-click in the field that corresponds to the list window. For example, while keying a claim, double click the Provider ID field to access the list window for providers. Enter information into the corresponding fields. Click the 'Save' button to add it to the list.



You can build the following lists using Provider Electronic Solutions: Each list type corresponds to a list window. Users may add, edit, or delete list records using list windows.

**Lists**

Button	Usage
Add	Pressing this button enables you to refresh the list screen so you may add a new record. Please note that if you key over data that already displays on the list window and press Save, you will overwrite the previous record. Be sure to press Add before entering a new record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Delete	Pressing this button enables you to delete the record currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the record currently being displayed.
Save	Pressing this button enables you to save the record you just added or modified. The saved record displays on the list at the bottom of the window.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or member ID.
Print	Pressing this button enables you to print the list.
Select	Pressing this button enables you to select the current list record to add to the current



Button	Usage
	transaction.
Help	Pressing this button enables a help screen to appear to answer any questions you may have.
Close	Pressing this button enables you to close the window.
Copy	Pressing this button enables you to build a new list from the current list record.

Below is a description of the buttons that display on each list window. The 'copy' button is not a feature on all list windows:

#### 4.2.1 To Add a New Record to a List

1. Click on the 'List' menu from the toolbar. To add a record, select the list by clicking on it.
2. Key information into all required fields. You can enter information in any order, or may enter it in the order presented on the record, pressing the Tab key to move to the next field.
3. Press the 'Save' button to save the record. **Note:** The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error.
4. Correct the mistake and press 'Save'.
5. Press the 'Add' button to add another record.

#### 4.2.2 To Modify a Record from the List

Click on the 'List' menu from the toolbar. To modify, select the list by clicking on it.

Scroll through the list of records that display at the bottom of the list window. Highlight the record you wish to modify, and perform one of the following:

1. Key over incorrect data on the record. Press 'Undo All' if you inadvertently overwrite a record.
2. Press 'Delete' to delete an unwanted record.

#### 4.2.3 To Find a Record in the List

Select the 'Find' button to display the Find pop-up window. Options are:

1. Find Where (select a field from the drop-down list, if applicable);
2. Find What (enter your search criteria here)
3. Search (select up or down from the drop-down list).



- Once you have entered the search criteria, click the 'Find Next' button with your mouse to search for the next record that matches the search criteria. Continue clicking 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.
- Press 'Cancel' when you have finished searching.

### 4.3 Completing the Provider List

The Billing Provider list allows you to collect detailed information about providers that can then be automatically entered into forms. This includes such information as: Provider ID Code Qualifier, Provider ID/NPI/License #, Entity Type Qualifier, Taxonomy Code, Last/Org Name, First name, Social Security number (SSN)/Employer ID, SSN/Employer ID Qualifier, and Provider Address

#### 4.3.1 To Add a New Provider

- Click on the 'List' menu from the toolbar. Select 'Provider' from the drop-down menu to add a record.
- Key information into all required fields. Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.
- A sample Provider list window is pictured below:

Field	Guidelines
Provider ID Code Qualifier	Choose a value based on the information entered in the Provider ID. Example: 1D – Indicates the number entered in the field is a billing Medicaid Provider number. XX – indicates the number entered in the field is



Field	Guidelines
	an NPI number. OB – indicates the State License Number of the Attending Physician.
Provider ID/ NPI/License #	Enter the provider's ID/NPI according to the format and policy in the Georgia Medicaid manual. A provider's ID will be nine numeric and 1, 2, or 3 alpha characters in length and NPI will be 10 numeric in length. A State License number can also be entered nine numeric and 1, 2, or 3 alpha characters in length.
Entity Type Qualifier	Choose a value based on the information entered in the Provider ID field. 1 – Indicates the number entered in the field belongs to a Person. 2 – Indicates the number entered in the field belongs to a Non-Person.
Taxonomy Code	This field lists the code designating the provider type, classification, and specialization. Required if registration with GA Medicaid for NPI included Taxonomy Code.
Last/Org Name	Based on the information entered in the Provider ID field, enter the name of the facility or the provider's last name.
First Name	If a "1" was chosen in the Entity Type Qualifier field, enter the provider's first name.
SSN/Employer ID	Enter the individual provider's nine-digit social security number or the Tax Identification number of the party being referenced. <b>Note:</b> If entering a Tax ID, include a hyphen after the two leading digits. Ex: 55-5555555
SSN/Employer ID Qualifier	Choose the best value: 24 –employer's identification number (Tax ID) or 34 – Social Security number.
Provider Address – Line 1	Enter the facility or provider's primary street address.
Line 2	Enter additional street information such as apartment number, or suite. This field is optional.
City	Enter the facility or provider's city.
State	Enter the facility or provider's state.
ZIP (+4)	Enter the facility or provider's ZIP Code. If the four-digit postal code is part of the NPI solution please enter.

4. Press the 'Save' button to save the record.

**The system returns error messages if the record contains errors. Scroll through**



**the error messages and double-click on each error to access the field on the record that contains the error.**

5. Correct the mistake(s) and press 'Save'.
6. Press the 'Add' button to add another record.

## 4.4 Completing the Member List

The Member list allows you to collect detailed information about members that can then be automatically entered into forms. This includes such information as: Member ID, ID Qualifier, Account number, SSN, Last Name, First Name, Middle Initial, Date of Birth, Gender, and Member's Address.

### 4.4.1 To Add a New Member

1. Click on the 'List' menu from the toolbar. Select 'Member' from the drop-down menu to add a record.
2. Key information into all required fields. Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.
3. A sample Member list window is pictured below:

hp Member

Member ID  ID Qualifier

Account #  SSN

Last Name  First Name  MI ☐

DOB  Gender

Member Address

Line 1  Line 2

City  State  Zip

Member ID	Last Name	First Name

Buttons: Add, Delete, Undo All, Save, Find..., Print..., Close



Field	Guidelines
Member ID	Enter the member's twelve-digit Georgia Medicaid ID.
ID Qualifier	This field auto-defaults to its proper settings, MI-Member Id.
SSN	Enter the member's nine-digit social security number. This field is optional.
Last Name	Enter the member's last name according to their eligibility verification.
First Name	Enter the member's first name according to their eligibility verification.
MI	Enter the member's middle initial according to their eligibility verification. This field is optional.
DOB (Date of Birth)	Enter the member's date of Birth in MM/DD/CCYY format.
Gender	Choose the best value to indicate the member's gender.
Member Address – Line 1	Enter the member's primary street address.
Line 2	Enter additional street information such as apartment number, or suite. This field is optional.
City	Enter the member city.
State	Enter the member's state.
ZIP (+4)	Enter the member's ZIP Code.

4. Press the 'Save' button to save the record.
5. The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error. Correct the mistake and press 'Save'.
6. Press the 'Add' button to add another record.



## 4.5 Completing the Policy Holder List

The Policy Holder list allows you to collect detailed information about a member's third party insurance that can then be automatically entered into forms. This includes such information as: Group #, Carrier Name, policyholder information, and so on.

### 4.5.1 To Add a New Policy Holder

1. Click on the 'List' menu from the toolbar. Select 'Member' from the drop-down menu to add a record.
2. Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field. A sample Member list window is pictured below:

Field	Guidelines
Member ID	Enter the member's twelve-digit Georgia Medicaid ID.
Group #	Enter the member's group number, assigned by the other insurance, if applicable.
Carrier Code	Choose a valid five-digit carrier code from the drop-down box that identifies the member's health plan. If you are unable to make a choice based on the list provided, double-click on this field to add a new valid Carrier Code. (An expanded list of Carrier Codes can be found on the



Field	Guidelines
	Georgia Medicaid Web site).
Carrier Name	This field auto-writes based on the information chosen in the Carrier Code field.
Other Insurance Group Name	Enter the Other Insurance's group (employer) name. This field is optional.
Insurance Type Code	Choose the best value to indicate the type of policy entered. AP Auto Insurance Policy C1 Commercial CP Medicare Conditionally Primary GP Group Policy HM Health Maintenance Organization (HMO) IP Individual Policy LD Long Term Care LT Litigation MB Medicare Part B MC Medicaid MI Medigap Part B MP Medicare Primary OT Other PP Personal Payment (Cash – No Insurance) SP Supplemental Policy ZZ Hospice claim
Relationship to Insured	Insured. 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 10 Foster Child 15 Ward 17 Stepson or Stepdaughter 18 Self 19 Child 20 Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent



Field	Guidelines
	29 Significant Other 32 Mother 33 Father 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child where insured has no financial responsibility 53 Life Partner 76 Dependent G8 Other Relationship
Last Name	Enter the last name of the policy holder.
First Name	Enter the first name of the policy holder.
ID Code	Enter the identification number of the policy holder.
ID Qualifier	Choose the best value to indicate the type of number entered in the Patient ID field. 1W Member ID Number IG Insurance Policy Number 23 Client Number SY Social Security Number
Date of Birth	Enter the date of birth of the policy holder in MM/DD/CCYY format
Gender	Choose the best value to indicate the gender of the policy holder.
Line 1	Enter the address of the policy holder.
Line 2	If applicable, enter the secondary address of the policy holder. Such as "Apt D or Ste 333".
City	Enter the city of the policy holder.
State	Enter the state of the policy holder in an abbreviated format. Ex: Georgia = GA
ZIP	Enter the ZIP Code of the policy holder.
Patient ID	Enter the patient's identification number; this may include the number assigned by the other insurance or their social security number. This field is optional.
ID Qualifier	Choose the best value to indicate the type of number entered in the Patient ID field. 1W Member ID Number IG Insurance Policy Number 23 Client Number



3. Press the 'Save' button to save the record.
4. The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error. Correct the mistake and press 'Save'.
5. Press the 'Add' button to add another record.




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## 5 Submitting 837 Dental Claims

This chapter provides instructions for submitting electronic 837 Dental claims. Please note this user manual does not discuss program requirements. Refer to the Georgia Medicaid Provider Handbooks for program-specific information.

Users access the Dental electronic claim form using one of the following methods:

1. Selecting the Dental icon from the toolbar 
2. Selecting Forms>>837 Dental

The electronic form displays with three tabs: Header 1, Header 2, and Service. The additional tab, if applicable, is: OI (Other Insurance).

### 5.1 Entering Claims in the Electronic Dental Form

Each tab on the Dental form contains four main parts:

1. Header line of fields that contain provider and member information
2. Updateable fields used to enter claims data
3. Buttons to the right of the form used to modify and save information entered in the updateable fields
4. List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to modify, copy, or print a claim record

Below is a description of the buttons that display on the claim form:

Button	Usage
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different members, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.



Button	Usage
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form in an "R" status.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or member ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

#### 5.1.1 To Add a New Claim

1. Access the 837 Dental form. Key information into all required fields. (All fields are required unless indicated as optional.) Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.
2. Press the 'Save' button to save the record.
3. The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.
4. Correct the mistake and press 'Save', or press 'Incomplete' to save the record with an incomplete status. Incomplete claims (status 'I') are not submitted with the batch submission.
5. Press the 'Add' button to add another claim.

#### 5.1.2 To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

1. Key over incorrect data on the claim form. ***You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete).*** Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
2. Press 'Copy' to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different members). Modify the new record accordingly. Save the new record.
3. Press 'Delete' to delete an unwanted record.



### 5.1.3 To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

1. Find Where (select a field from the drop-down list, if applicable)
2. Find What (enter your search criteria here)
3. Search (select up or down from the drop-down list).
4. Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.
5. Press 'Cancel' when you have finished searching.
- 6.

## 5.2 Fields on the 837 Dental Claim Form

### 5.2.1 Header 1 Tab

Below is a sample electronic 837 Dental form displaying the Header 1 tab:

**837 Dental Claim**

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 | Header 2 | Header 3 | Service 1 | Service 2

Claim Frequency 1 Original Claim #

Billing Provider ID/NPI Taxonomy Code

Last/Org Name First Name

Pay-to Provider ID/NPI Taxonomy Code

Last/Org Name First Name

Member ID Account #

Last Name First Name MI

Release of Medical Data Y Benefits Assignment Y

Report Transmission Code Report Type Code Attachment Ctl

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------

Find... Print Close



Complete the following fields under the Header 1 tab to submit an 837 Dental claim:

Field	Guidelines
Claim Frequency	Leave as "1" unless filing an adjustment or a void of an existing claim. 1 Original (Admit Thru Discharge Claim) 7 Replacement (Replacement of Prior Claim) 8 Void (Void/Cancel of Prior Claim)
Original Claim #	If a value other than 1 was entered in the Claim Frequency field, you must enter the Internal Control Number (ICN)/Transaction Control Number (TCN) for the claim you are adjusting or voiding. For additional information on completing this process, please refer to the Void & Adjustment section of this guide.
Billing Provider ID/NPI	Choose the appropriate billing provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Pay-to Provider ID/NPI	Use only if different than the Billing Provider ID. Choose the appropriate payee provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Member ID	Choose the Member's twelve-digit Medicaid number from your member list. If you have not added the required ID to your list, double-click on this field to do so.
Account #	This field will auto-populate based upon your choice in the Member ID field.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.
MI	This field will auto-populate.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.



Field	Guidelines
Report Transmission Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Report Type Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Attachment Ctl	Required if sending a paper attachment separate from the claim. Enter a unique identification code for the attachment that is being sent. This code is alphanumeric and the maximum length allowed is eighty characters. Be sure to document this number, the member ID, and your provider number clearly on the attachment, along with the cover sheet. For more information on attachments, please visit <a href="http://www.mmis.georgia.gov">www.mmis.georgia.gov</a> .

### 5.2.2 Header 2 Tab

Below is a sample electronic 837 Dental form displaying the Header 2 tab:

**837 Dental Claim**

Total Charge: .00 OI Amount: .00 Billed Amount: .00 Services: 1

Header 1 **Header 2** Header 3 Service 1 Service 2

**Referring Provider**

Provider ID/NPI: [ ] Taxonomy Code: [ ]

Last/Org Name: [ ] First Name: [ ]

Encounter Ind: CH EPSDT: N Place Of Service: [ ]

Admission Date: 00/00/0000

Prior Auth/Referral Qualifier: 1 [ ] Prior Auth/Referral Number: 1 [ ]

Prior Auth/Referral Qualifier: 2 [ ] Prior Auth/Referral Number: 2 [ ]

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------

Buttons: Add, Copy, Delete, Undo All, Save, Find..., Print, Close

Complete the following fields under the Header 2 tab to submit an 837 Dental claim:

Field	Guidelines
Referring Provider ID/	If applicable, choose the appropriate referring provider ID/NPI from



Field	Guidelines
NPI	your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on the information chosen in the Referring Provider ID/NPI field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Encounter Indicator	If this claim is an encounter claim, choose the appropriate value. The value "CH" will automatically default and should remain as the selected option to be considered for payment.
EPSDT Indicator	Change to "Y" if services rendered are part of a Georgia Medicaid Child Health Check Up (CHCUP/EDPST) program.
Place of Service	Choose the best value to indicate where the service took place.
Admission Date	If applicable, enter admission date.
Prior Auth/Referral Qualifier 1	Required if Medipass authorization or Prior Authorization was obtained for services being billed. Choose the appropriate qualifier from the drop-down menu. (SEE NOTE BELOW)
Prior Auth/Referral Number 1	Required if Medipass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this claim. (SEE NOTE BELOW)
Prior Auth/Referral Qualifier 2	Required if Medipass authorization or Prior Authorization was obtained for services being billed. Choose the appropriate qualifier from the drop-down menu. (SEE NOTE BELOW)
Prior Auth/Referral Number 2	Required if Medipass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this claim. (SEE NOTE BELOW)

**Note:** If the claim requires the entry of a Referral number and a Prior Authorization number, the Referral qualifier must be selected in the Prior Auth/Referral Qualifier 1 field and the Referral number must be entered in the Prior Auth/Referral Number 1 field; the Prior Authorization qualifier must be selected in the Prior Auth/Referral Qualifier 2 field and the Prior Authorization number must be entered in the Prior Auth/Referral Number 2 field.



### 5.2.3 Header 3 Tab

Below is a sample electronic 837 Dental form displaying the Header 3 tab:

**837 Dental Claim**

Total Charge: .00 OI Amount: .00 Billed Amount: .00 Services: 1

Header 1 | Header 2 | **Header 3** | Service 1 | Service 2

**Accident**

Related Causes: 1 [ ] 2 [ ] 3 [ ] Date: 00/00/0000

State: [ ] Country: [ ]

**Service Facility**

Provider ID/NPI: [ ] Taxonomy Code: [ ]

Last/Org Name: [ ]

Other Insurance Indicator: N [ ]

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------

Find...  
Print  
Close

Complete the following fields under the Header 3 tab to submit an 837 Dental claim:

Field	Guidelines
Accident: Related Causes (1,2,3)	If applicable, choose the best value to indicate if services were provided as a result of an accident.
Date	If applicable, enter the date of the accident if services are the result of an accidental injury in MM/DD/CCYY format.
State	If applicable, enter the state that the accident occurred in an abbreviated format. For example, GA for Georgia.
Country	If applicable, enter the country that the accident occurred in an abbreviated format. For example, USA for United States of America.
Other Insurance Ind	Choose the best value to indicate whether or not the member has other insurance besides Georgia Medicaid.



### 5.2.4 OI Tab (Other Insurance)

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes'. Below is a sample electronic 837 Dental form displaying the OI tab.

Complete the following fields under the OI (Other Insurance) tab to submit an 837 Dental claim:

Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Claim Filing Ind Code	Choose the best value to indicate the category of the member's other insurance. Ex: CI: Commercial Insurance Co.
Payer Responsibility	Choose the best value to indicate the member's insurance coverage status to Medicaid. P = Primary ; S = Secondary; T = Tertiary
Paid Amount	Enter the dollars and cents that were paid towards the service(s) being



Field	Guidelines
	billed.
Policy Holder Group #	Choose the appropriate Policy Holder Group number from your Policy Holder list. If you have not added the group number to your list, double-click on this field to do so.
Group Name	This field will auto-populate based on the information chosen in the Group Number field.
Carrier Code	This field will auto-populate.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.

### 5.2.5 Service 1 Tab

Below is a sample electronic 837 Dental form displaying the Service 1 tab.

The screenshot shows the '837 Dental Claim' window with the 'Service 1' tab selected. The form includes fields for 'Total Charge', 'OI Amount', 'Billed Amount', and 'Services' (set to 1). Below these are tabs for 'Header 1', 'Header 2', 'Header 3', 'OI', 'Service 1', and 'Service 2'. The 'Service 1' tab contains fields for 'Date Of Service' (00/00/0000), 'Place Of Service', 'Procedure', 'Line Item Ctl', 'Tooth', 'Modifiers' (1-4), 'Surfaces' (1-5), 'Quadrants' (1-5), 'Units' (.00), 'Billed Amount' (.00), and 'Service Adjustment Ind' (N). A table at the bottom lists service items with columns: Srv #, Date Of Service, PlaceOfService, Procedure, Units, and Billed Amount. The first row shows Srv # 1, Date Of Service 00/00/0000, Units .00, and Billed Amount .00. On the right side, there are buttons for 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Find...', 'Print', and 'Close'.

Complete the following fields under the Service 1 tab to submit an 837 Dental claim:



Field	Guidelines
Date of Service	Enter the Date of Service for the procedure being billed in MM/DD/CCYY format. For complete and partial dentures, this is the date of service the dentures are seated.
Place of Service	Choose the best value to indicate where the service took place. Ex: 11 for Office
Procedure	Enter the appropriate ADA procedure code for the procedure being billed.
Line Item Ctl	This field is recommended to serve as a tracking identifier.
Tooth	If applicable to procedure billed, enter the appropriate tooth number.
Modifiers	If applicable to procedure billed, enter all appropriate modifiers.
Surfaces	If applicable to procedure billed, choose the appropriate tooth surface of the tooth on which the service is performed.
Quadrants	If applicable, choose the best value to indicate the area of the oral cavity (mouth) where treatment is being performed.
Units	Enter the amount of units/quantity being billed for the particular procedure code. If the procedure is performed on different teeth, a separate line of service must be entered.
Billed Amount	Enter the usual and customary charges for each line of service listed. Enter in DD.CC format. Charges must not be higher than the fees charged to private pay patients.
Service Adjustment Indicator	If applicable, choose the best value to acknowledge "Other Insurance (OI)" adjudication.

If the *Service Adjustment Indicator* field was marked as "Yes," click on and complete the Service 3 tab.

### **Adding, Deleting, or Copying a Service**

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.



### 5.2.6 Service 2 Tab

Below is a sample electronic 837 Dental form displaying the Service 2 tab.

**837 Dental Claim**

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 | Header 2 | Header 3 | OI | Service 1 | **Service 2**

Appliance Placement Date 00/00/0000 OI Allowed Amount .00

Anesthesia Quantity Qualifier Anesthesia Unit Count 0

Rendering Provider

Provider ID/NPI Taxonomy Code

Last/Org Name First Name

Srv #	Date Of Service	Place Of Service	Procedure	Units	Billed Amount
1	00/00/0000			.00	.00

Member ID Last Name First Name Billed Amount Last Submit Dt Status

Find... Print Close

Complete the following fields under the Service 2 tab to submit an 837 Dental claim:

Field	Guidelines
Appliance Placement Date	If applicable, enter the date orthodontic appliances were placed in a MM/DD/CCYY format. Required field for orthodontic services.
Anesthesia Quantity Qualifier	If applicable, choose the appropriate qualifier. Required field on anesthesia service lines if one or more extenuating circumstances were present at the time of service.
Anesthesia Unit Count	If applicable, enter the amount of anesthesia units used for this service line. Optional field.
Rendering Provider ID/NPI	Choose a provider ID from your Provider ID list to indicate which provider performed the service. If you have not added the required ID to your list, double-click on this field to do so. This field is only applicable if billing with a group provider number.
Taxonomy Code	This field will auto-populate based on the information chosen in the Rendering Provider ID/NPI field.



Field	Guidelines
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.

### 5.2.7 Service 3 Tab

Below is a sample electronic 837 Dental form displaying the Service 3 tab. This tab needs to be completed for each service line. To navigate to Service Tab 3, you must first choose "Y" on the Other Insurance Indicator field on Header 3. Secondly, you must choose "Y" on the Service Adjustment Ind field on Service Tab 1.

**837 Dental Claim**

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 | Header 2 | Header 3 | OI | Service 1 | Service 2 | **Service 3**

Adjustment Group Cd [dropdown]

Reason Codes/Amts: 1 [ ] .00 2 [ ] .00

Paid Date/Amount 00/00/0000 .00 3 [ ] .00

Carrier

Code [dropdown]

Name [text box]

Member ID | Last Name | First Name | Billed Amount | Last Submit Dt | Status

Add  
Copy  
Delete  
Undo All  
Save  
Find...  
Print  
Close

Complete the following fields under the Service 3 tab to submit an 837 Dental claim:

Field	Guidelines
Adjustment Group Cd	Choose the best value.
Reason Codes/Amts	If applicable, choose the appropriate qualifier.
Paid Date/Amount	If applicable, enter the date the other insurance paid and the corresponding dollars and cents that were paid towards the service(s) being billed. Enter in a DD.CC format.



Field	Guidelines
Carrier Code	Choose the appropriate Carrier Code from your Carrier list. If you have not added the carrier to your list, double-click on this field to do so.
Name	This field will auto-populate.

After completing all necessary fields and reviewing entered data for accuracy, press Save to add your claim to the Claim List.

#### 5.2.7.1 To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

1. Key over incorrect data on the claim form. You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete). Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
2. Press 'Copy' to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different members). Modify the new record accordingly. Save the new record.
3. Press 'Delete' to delete an unwanted record.

#### 5.2.7.2 Submitting Voids/Adjustments to a Paid Claim (if claim you wish to Void/Adjust is in your claim list)

1. Find the Claim you wish to Void/Adjust from the Dental List. Press Copy.
2. In the Claim Frequency field, change the indicator to inform Medicaid if the request is an Adjustment/Replacement or a Claim Void. Enter either a "7" for an adjustment or an "8" for a void.

#### **CLAIM FREQUENCY:**

- a. 7 (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously created claim.
  - b. 8 (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.
3. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim has been accepted and paid. This information can be located on your Remittance Advice.



- a. If the value '7' was chosen, make any necessary corrections/adjustments to the current claim.
  - b. If the value '8' was chosen, please continue with Step 4.
4. Press 'Save' to save your claim, and follow Section 5.3 Submitting Claims through the Web Server.

**Note:** To adjust or void a paid claim, wait until you have received your Remittance Advice listing the paid claim's ICN/TCN.

#### 5.2.7.3 Submitting Voids/Adjustments to a Paid Claim (if claim you wish to Void/Adjust is NOT in your claim list)

1. Enter your claim as you normally would, complete all necessary fields.
2. In the Claim Frequency field, change the indicator to inform Medicaid if the request is an Adjustment/Replacement or a Void. Enter either a "7" for an adjustment or an "8" for a void.

#### **CLAIM FREQUENCY**

- a. 7 (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously created claim.
  - b. 8 (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.
3. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim has been accepted and paid. This information can be located on your Remittance Advice.
  - a. If the value '7' was chosen, make any necessary corrections/adjustments to the current claim.
  - b. If the value '8' was chosen, please continue with Step 4.
4. Press 'Save' to save your claim, and follow Section 5.3 Submitting Claims through the Web Server.

**Note:** To adjust or void a paid claim, wait until you have received your Remittance Advice listing the paid claim's ICN/TCN.



### 5.3 Submitting Claims through the Web Server

Select Communication>>Submission to display the Batch Submission window, pictured below:

1. Determine which files you want to send from the 'Files to Send' list. Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.
2. Determine which files you want to receive from the 'Files to Receive' list. Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.
3. Press 'Submit' to send and/or receive files. Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.
4. After submission, follow Steps 1-3 to receive the response from the Web server.

Refer to "Receiving a Response" on page 10-1, for information about receiving responses, resubmitting files, and reviewing submission reports.

**Note:** When you submit batch transactions, you must wait a period of time (fifteen minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files remember you are *receiving responses from your last transaction, not the current transmission*. You must view the response to find if your claims were accepted or rejected. Claims rejected will not appear on your Remittance Advice.



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## 6 Submitting 837 Professional Claims

This chapter provides instructions for submitting electronic 837 Professional claims. Please note this user manual does not discuss program requirements. Refer to the Georgia Medicaid Provider Manual for program-specific information.

### 6.1 General Instructions for Entering Electronic Claims

Users access the 837 Professional electronic claim form using one of the following methods:

1. Selecting the 837 Professional icon from the toolbar 
2. Selecting Forms>>837 Professional. The electronic form displays with five tabs: Header 1, Header 2, Header 3, Service 1 and Service

The additional tabs, if applicable, are: OI (Other Insurance), Crossover, and RX.

### 6.2 Entering Claims in the Electronic 837 Professional Forms

Each tab on the 837 Professional form contains four main parts:

1. Header line of fields that contain provider and member information.
2. Updateable fields used to enter claims data.
3. Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
4. List fields at the bottom of the form that enable users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Member ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	Usage
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record that has been submitted previously. This feature is especially helpful if you routinely



Button	Usage
	submit claims for the same procedure code, but different members, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or member ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

#### 6.2.1 To Add a New Claim

1. Access the 837 Professional form. Key information into all required fields.
2. Field descriptions are provided in section 8.2 *837 Professional form* in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.
3. Press the 'Save' button to save the record. The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.
4. Correct each mistake and press 'Save', or press 'Incomplete' to save the record with an incomplete status. Incomplete claims (status 'I') are not submitted with the batch submission.
5. Press the 'Add' button to add another claim.

#### 6.2.2 To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

1. Key over incorrect data on the claim form. You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete). Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
2. Press 'Copy' to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different members) and modify the new record accordingly. Save the new record.



3. Press 'Delete' to delete an unwanted record.

### 6.2.3 To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

1. Find Where (select a field from the drop-down list, if applicable);
2. Find What (enter your search criteria here)
3. Search (select up or down from the drop-down list).
4. Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.
5. Press 'Cancel' when you have finished searching.

## 6.3 837 Professional Form

### 6.3.1 Header 1 Tab

Below is a sample electronic 837 Professional form displaying the Header 1 tab:

The screenshot shows the '837 Professional Claim' window with the 'Header 1' tab selected. The form contains various input fields for claim information, including Total Charge, OI Amount, Billed Amount, and Services. It also includes sections for Billing Provider, Pay-to Provider, Member ID, and Medical Record details. A table at the bottom lists claim details with columns for Member ID, Last Name, First Name, Billed Amount, Last Submit Dt, and Status. On the right side, there are buttons for Add, Copy, Delete, Undo All, Save, Edit All, Find..., Print, and Close.

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------



Complete the following fields under the Header 1 tab to submit an 837 Professional claim:

Field	Guidelines
Claim Frequency	Leave as "1" unless filing an adjustment or a void of an existing claim. 1: Original (Admit Thru Discharge Claim) 7: Replacement (Replacement of Prior Claim) 8: Void (Void/Cancel of Prior Claim)
Attachment Ctl	Required if sending a paper attachment separate from the claim. Enter a unique identification code for the attachment that is being sent. This code is alphanumeric and the maximum length allowed is eighty characters. Be sure to document this number, the member ID, and your provider number clearly on the attachment, along with the cover sheet. For more information on attachments, please visit <a href="http://www.mmis.georgia.gov">www.mmis.georgia.gov</a> .
Original Claim #	If a value other than 1 was entered in the Claim Frequency field, you must enter the ICN/TCN for the claim you are adjusting or voiding. For additional information on completing this process, please refer to the Void & Adjustment section of this guide.
Billing Provider ID/ NPI	Choose the appropriate billing provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Pay-to Provider ID/ NPI	Use if only different than the Billing Provider ID. Choose the appropriate payee provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.



Field	Guidelines
Member ID	Choose the Member's twelve-digit Medicaid number from your member list. If you have not added the required ID to your list, double-click on this field to do so.
Account #	This field will auto-populate based upon your choice in the Member ID field.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.
MI	This field will auto-populate.
Medical Record # (Optional)	Enter the medical record number, assigned to the member, by the provider, for the service that was performed. This field will accept up to thirty alphanumeric characters. This field is optional.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Patient Signature	Choose the best value to indicate whether or not the patient's signature is on file.
Report Transmission Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Report Type Code	Required if sending a paper attachment separate from the claim. Select the item that applies.

### 6.3.2 Header 2 Tab

Below is a sample electronic 837 Professional form displaying the Header 2 tab.



Complete the following fields under the Header 2 tab to submit an 837 Professional claim:

Field	Guidelines
Diagnosis Code	Choose a valid diagnosis code from your diagnosis code list. Code should be three- to five-digits with no decimal point. <b>Note:</b> A second diagnosis code is required for GA Medicaid Regional Perinatal Intensive Care (RPICC) claims.
Referring Provider ID/ NPI	If applicable, choose the appropriate referring provider ID/NPI from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on the information chosen in the Referring Provider ID/NPI field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Encounter Indicator	If this claim is an encounter claim, choose the appropriate value. The value "CH" will automatically default and should remain as the selected option to be considered for payment.
Special Program Code	If this is an EPSDT/CHCUP claim, choose 01 EPSDT.
Place of Service	Choose the best value to indicate where the services were rendered.



Field	Guidelines
EPSDT Referral Certification Condition Indicator	If this is an EPSDT/CHCUP claim, choose yes or no. If the screening result was normal, check NO for Certification Condition Indicator and select "Not Used" for the Condition.
Condition Indicator	If this is an EPSDT/CHCUP claim, choose the best value. If the screening result was normal, select "Not Used" for the Condition.

### 6.3.3 Header 3 Tab

Below is a sample electronic 837 Professional form displaying the Header 3 tab.

**837 Professional Claim**

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 | Header 2 | **Header 3** | Header 4 | Service 1 | Service 2

**Accident**

Related Causes: 1 [ ] 2 [ ] 3 [ ] Date 00/00/0000

State [ ] Country [ ]

Admission Date 00/00/0000 Mammography Certification Nbr [ ]

Other Insurance Indicator N [ ] Crossover Indicator N [ ]

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------

Find...  
Print  
Close

Complete the following fields under the Header 3 tab to submit an 837 Professional claim:

Field	Guidelines
Accident: Related Causes	If applicable, choose the best value to indicate if services were provided as a result of an accident.
Date	If applicable, enter the date of the accident if services are the result of an accidental injury in MM/DD/CCYY format.
State	If applicable, enter the state that the accident occurred in an abbreviated format. For example, GA for Georgia.



Field	Guidelines
Country	If applicable, enter the country that the accident occurred in an abbreviated format. For example, USA for United States of America.
Admission Date	If applicable, enter admission date.
Other Insurance Indicator	Choose the best value to indicate whether or not the member has other insurance besides Georgia Medicaid.
Crossover Indicator	Choose the best value to indicate if the claim is a crossover from Medicare.

#### 6.3.4 Header 4 Tab

Below is a sample electronic 837 Professional form displaying the Header 4 tab.

**837 Professional Claim**

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 Header 2 Header 3 **Header 4** Service 1 Service 2

**Service Facility**

Provider ID/NPI  Taxonomy Code

Last/Org Name

Prior Auth/Referral Qualifier: 1  Prior Auth/Referral Number: 1

Prior Auth/Referral Qualifier: 2  Prior Auth/Referral Number: 2

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------

Find...  
Print  
Close

Complete the following fields under the Header 4 tab to submit an 837 Professional claim:

Field	Guidelines
Service Facility Provider ID/NPI	If applicable, choose the appropriate Facility ID from your list. If you have not added the required ID to your list, double-click on this field to do so.



Field	Guidelines
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID/NPI field.
Last/Org Name	This field will auto-populate.
Prior Auth/Referral Number 1	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this claim. (SEE NOTE BELOW)
Prior Auth/Referral Qualifier 2	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Choose the appropriate qualifier from the drop-down menu. (SEE NOTE BELOW)
Prior Auth/Referral Number 2	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this claim. (SEE NOTE BELOW)

**Note:** If the claim requires the entry of a Referral number and a Prior Authorization number, the Referral qualifier must be selected in the Prior Auth/Referral Qualifier 1 field and the Referral number must be entered in the Prior Auth/Referral Number 1 field; the Prior Authorization qualifier must be selected in the Prior Auth/Referral Qualifier 2 field and the Prior Authorization number must be entered in the Prior Auth/Referral Number 2 field.

#### 6.3.5 OI Tab (Other Insurance)

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes' in Header 3. Below is a sample electronic 837 Professional form displaying the OI (Other Insurance) tab. \



837 Professional Claim

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 Header 2 Header 3 Header 4 **OI** Service 1 Service 2

Release of Medical Data Benefits Assignment Y Patient Signature  
Claim Filing Ind Code Payer Responsibility  
Paid Amount .00

Policy Holder  
Group # Group Name Carrier Code  
Last Name First Name

Srv #	Carrier Code	Group #	Group Name	Last Name
1				

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------

Find...  
Print  
Close

Complete the following fields under the Other Insurance tab to submit an 837 Professional claim:

Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Patient Signature	Choose the best value to indicate whether or not the patient's signature is on file.
Claim Filing Ind Code	Choose the best value to indicate the category of the member's other insurance. Ex: CI: Commercial Insurance Co.
Payer Responsibility	Choose the best value to indicate the member's insurance coverage status to Medicaid. P = Primary; S = Secondary; T = Tertiary
Paid Amount	Enter the dollars and cents that were paid towards the service(s) being billed. Enter in DD.CC format.
Policy Holder Group #	Choose the appropriate Policy Holder Group number from your Policy Holder list. If you have not added the group number to your list, double-



Field	Guidelines
	click on this field to do so.
Group Name	This field will auto-populate based on the information chosen in the Group Number field.
Carrier Code	This field will auto-populate.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.

### 6.3.6 Crossover Tab

Completing the Crossover tab is required if an indicator in the *Crossover Ind* field was marked as 'Yes' in Header 3. If the claim is Medicare related, this tab allows you to enter the information based on the **payment** made. Below is a sample 837 Professional form displaying the Crossover tab.

The screenshot shows the '837 Professional Claim' window with the 'Crossover' tab selected. The window has a blue title bar and standard Windows window controls. The main area is divided into several sections. At the top, there are fields for 'Total Charge', 'OI Amount', 'Billed Amount', and 'Services'. Below these are tabs for 'Header 1', 'Header 2', 'Header 3', 'Header 4', 'OI', 'Crossover' (selected), 'Service 1', and 'Service 2'. The 'Crossover' tab contains fields for 'Release of Medical Data' (a dropdown menu), 'Benefits Assignment' (a dropdown menu with 'Y' selected), 'Patient Signature' (a dropdown menu), 'Paid Amount' (a text field with '.00'), and 'Paid Date' (a text field with '00/00/0000'). Below these is a 'Policy Holder' section with fields for 'Carrier Code', 'Last Name', and 'First Name'. At the bottom, there is a table with columns: 'Member ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'. On the right side of the window, there is a vertical stack of buttons: 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Edit All', 'Find...', 'Print', and 'Close'.

Complete the following fields under the Crossover tab to submit an 837 Professional claim:



Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Patient Signature	Choose the best value to indicate whether or not the patient's signature is on file.
Paid Amount	Enter the total amount Medicare paid toward the claim. Enter in DD.CC format.
Paid Date	Enter the date Medicare paid the claim in MM/DD/CCYY format.
Policy Holder Carrier Code	Choose the appropriate code from drop-down menu.
Last Name	This field will auto-populate based on the information chosen in the Carrier Code field.
First Name	This field will auto-populate.

#### 6.3.7 Service 1 Tab

Below is a sample electronic 837 Professional form displaying the Service 1 tab.



Complete the following fields under the Services 1 tab to submit an 837 Professional claim:

Field	Guidelines
Billed Amount	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients. Enter in DD.CC format.
Family Planning Indicator	Choose yes if the services relate to a pregnancy or if the services were for family planning.
Line Item Ctl	This field is recommended to serve as a tracking identifier.
Service Adjustment Indicator	If applicable, choose the best value to acknowledge "Other Insurance (OI)" adjudication.

If the *Service Adjustment Indicator* field was marked as "Yes," click on and complete the Service 3 tab.

#### 6.3.7.1 Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

#### 6.3.8 Service 2 Tab

Below is a sample electronic 837 Professional form displaying the Service 2 tab.



Complete the following fields under the Service 2 tab to submit an 837 Professional claim:

Field	Guidelines
Ambulance Transport Code	If the place of service on current claim is Ambulance, please complete this field. Choose the best value that describes the trip indicator for the claim.
Ambulance Transport Reason Code	If the place of service on current claim is Ambulance, please complete this field. Choose the best value that describes the reason for the transport trip.
Transport Distance	If the place of service on current claim is Ambulance, please complete this field. Enter the total miles traveled as it relates to this claim.
Patient Weight (Optional)	If the place of service on current claim is Ambulance, please complete this field. Enter the patient's approximate weight. This field is optional.
Condition Codes	If the place of service on current claim is Ambulance, please complete this field. Choose the best value that describes patient's condition.
RoundTrip Purpose	If the place of service on current claim is Ambulance, please complete this field ONLY if transport was roundtrip. Choose the best value that describes the purpose of a roundtrip transport.
Rendering Provider ID/NPI	Choose a provider ID from your provider ID/NPI list to indicate which provider performed the service. If you have not added the required ID to your list, double-click on this field to do so. This field is only applicable if



Field	Guidelines
	billing with a group provider number.
Rendering Provider Taxonomy Code	This field will auto-populate based on the information chosen in the Rendering Provider ID/NPI field.
Rendering Last/Org Name	This field will auto-populate.
Rendering First Name	This field will auto-populate.
RX Indicator	If the procedure you are billing requires a NDC (National Drug Code) according to Georgia Medicaid Policy, please choose yes and complete the RX tab before adding any additional line items.

### 6.3.9 Service 3 Tab

Below is a sample electronic 837 Professional form displaying the Service 3 tab.

The screenshot shows the '837 Professional Claim' window with the 'Service 3' tab selected. The top bar displays 'Total Charge .00', 'OI Amount .00', 'Billed Amount .00', and 'Services 1'. The 'Service 3' tab is active, showing 'Header 2', 'Header 3', 'Header 4', 'OI', 'Crossover', 'Service 1', 'Service 2', and 'Service 3'. The 'TPL Adjustment' section includes 'Adjustment Group Cd', 'Reason Codes/Amts:1', 'Paid Date/Amount', and 'Carrier Code'. The 'Crossover Adjustment' section includes 'Adjustment Group Cd', 'Reason Codes/Amts:1', 'Paid Date/Amount', and 'Carrier Code'. A table at the bottom lists 'Member ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'. On the right side, there are buttons for 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Edit All', 'Find...', 'Print', and 'Close'.

Complete the following fields under the Service 3 tab to submit an 837 Professional claim:

Field	Guidelines
TPL Adjustment Group	Choose the best value.



Field	Guidelines
Cd	
Reason Codes/Amts	If applicable, choose the appropriate code and then enter the corresponding amount in DD.CC format.
Paid Date/Amount	If applicable, enter the date the other insurance paid and the corresponding dollars and cents that were paid towards the service(s) being billed. Enter in a DD.CC format.
Carrier Code	Choose the appropriate Carrier Code from your Carrier list. If you have not added the carrier to your list, double-click on this field to do so.
Carrier Name	This field will auto-populate.
Crossover Adjustment Group Cd	Choose the best value.
Reason Codes/Amts	If applicable, choose the appropriate code and then enter the corresponding amount in DD.CC format.
Paid Date/Amount	If applicable, enter the date Medicare paid and the corresponding dollars and cents that were paid towards the service(s) being billed. Enter in a DD.CC format.
Carrier Code	Choose the appropriate Carrier Code from your Carrier list. If you have not added the carrier to your list, double-click on this field to do so.
Carrier Name	This field will auto-populate.

#### 6.3.10 RX Tab

Completing the RX tab is required if an indicator in the *Rx Ind* field was marked as 'Yes'. If the claim requires an NDC, this tab will allow you to enter the appropriate information. Below is a sample 837 Professional form displaying the RX tab.



Complete the following fields under the RX tab to submit an 837 Professional claim:

Field	Guidelines
Pharmaceutical NDC	Choose an NDC code from your NDC list to indicate which applies to this service. If you have not added the required NDC to your list, double-click on this field to do so.
Quantity	Enter the quantity of the drug indicated by the NDC that is being billed.
Unit Price	Enter the cost per unit of the NDC indicated that is billed to the patient. Leave as ".00" if the price per unit is unknown.
Unit of Measurement	Select the unit that was used for measuring the quantity of the NDC.

#### 6.3.10.1 Adding, Deleting, or Copying a (RX)

Use the buttons to the left of the form to add, delete, or copy a RX. Once you copy a RX, you can modify it as necessary.

After completing all necessary fields and reviewing entered data for accuracy, **press Save** to add your claim to the Claim List.



### 6.3.10.2 To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

1. Key over incorrect data on the claim form. ***You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete).*** Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
2. Press 'Copy' to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different members). Modify the new record accordingly. Save the new record.
3. Press 'Delete' to delete an unwanted record.

### 6.3.10.3 Submitting Voids/Adjustments to a Paid Claim (if claim you wish to Void/Adjust is in your claim list)

1. Find the Claim you wish to Void/Adjust from the Professional List. Press Copy.
2. In the Claim Frequency field on Header 1, change the indicator to inform Medicaid if the request is an Adjustment/Replacement or a Void. Enter either a "7" for an adjustment or a "8" for a void.

#### **CLAIM FREQUENCY**

- a. 7 (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously created claim.
  - b. 8 (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.
3. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim was accepted and paid. This information can be located on your *Remittance Advice*.
    - a. If the value '7' was chosen, make any necessary corrections/adjustments to the current claim.
    - b. If the value '8' was chosen, please continue with Step 4.
  4. Press 'Save' to save your claim, and follow Section 5.3 Submitting Claims through the Web Server.

**Note:** To adjust or void a paid claim, wait until you have received your Remittance Advice listing the paid claim's ICN/TCN.



#### 6.3.10.4 Submitting Voids/Adjustments to a Paid Claim (if claim you wish to Void/Adjust is NOT in your claim list)

1. Enter your claim as you normally would, complete all necessary fields.
2. In the Claim Frequency field, change the indicator to inform Medicaid if the request is an Adjustment/Replacement or a Claim Void. Enter either a "7" for an adjustment or a "8" for a void.

#### **CLAIM FREQUENCY**

- a. 7 (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued claim.
  - b. 8 (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.
3. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim was accepted and paid. This information can be located on your *Remittance Advice*.
    - a. If the value '7' was chosen, make any necessary corrections/adjustments to the current claim.
    - b. If the value '8' was chosen, please continue with Step 4.
  4. Press 'Save' to save your claim, and follow Section 6.3 Submitting Claims through the Web Server.

**Note:** To adjust or void a paid claim, wait until you have received your Remittance Advice listing the paid claim's ICN/TCN.



## 6.4 Submitting Claims through the Web Server

Select Communication>>Submission to display the Batch Submission window, pictured below:

The screenshot shows the 'Batch Submission' window. The 'Method' is set to 'Web Server'. The 'Files To Send' list includes 837 Dental, 837 Institutional Inpatient, 837 Institutional Nursing Home, 837 Institutional Outpatient, and 837 Professional. The 'Files To Receive' list includes 824 Claim Acknowledgement(s). The window has 'Select All' and 'Deselect All' buttons for both lists, and 'Submit' and 'Close' buttons at the bottom right.

1. Determine which files you want to send from the Files to Send list. Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.
2. Determine which files you want to receive from the 'Files to Receive' list. Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.
3. Press 'Submit' to send and/or receive files. Provider Electronic Solutions connects to the web server and sends the response. The Verification Log (accessible by selecting Communication>>View Verification) and the Communication Log (accessible by selecting Communication>>View Communication Log) provide information regarding the transaction.
4. After submission, follow Steps 1-3 to receive the response from the Web Server.

Refer to "Receiving a Response" on page 133, for information about receiving responses, resubmitting files, and reviewing submission reports.


**Note:** When you submit batch transactions, you must wait a period of time (fifteen minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files, remember you are *receiving responses for any previous transmission where you have not already retrieved a response file, not the current transmission.*



## 7 Submitting 837 Institutional Inpatient Claims

This chapter provides instructions for submitting electronic 837 inpatient claims. Please note this user manual does not discuss program requirements. Refer to the Georgia Medicaid Provider Manual for program-specific information.

Users access the electronic 837 Institutional Inpatient claim form using one of the following methods:

1. Selecting the 837 Institutional Inpatient icon from the toolbar 
2. Selecting Forms>>837 Institutional Inpatient

The electronic form displays with six tabs: Header 1, Header 2, Header 3, Header 4, Header 5, and Service. The additional tabs, if applicable, are: OI (Other Insurance) and Crossover.

### 7.1 Entering Claims in the 837 Institutional Inpatient Form

Each tab on the 837 Institutional Inpatient form contains four main parts:

1. Header line of fields that contain provider and member information.
2. Updateable fields used to enter claims data.
3. Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
4. List fields at the bottom of the form which enables users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Member ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	Usage
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different members, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.



Button	Usage
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or member ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

#### 7.1.1 To Add a New Claim

1. Access the 837 Institutional Inpatient form. Key information into all required fields. Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.
2. Press the 'Save' button to save the record. The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.
3. Correct each mistake and press 'Save', or press Incomplete to save the record with an incomplete status. Incomplete claims (status 'I') are not submitted with the batch submission.
4. Press the 'Add' button to add another claim.

#### 7.1.2 To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

1. Key over incorrect data on the claim form. You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete). Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
2. Press 'Copy' to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different members) and modify the new record accordingly. Save the new record.
3. Press 'Delete' to delete an unwanted record.



### 7.1.3 To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

1. Find Where (select a field from the drop-down list, if applicable);
2. Find What (enter your search criteria here)
3. Search (select up or down from the drop-down list).
4. Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.
5. Press 'Cancel' when you have finished searching

## 7.2 837 Institutional Inpatient Form

### 7.2.1 Header 1 Tab

Below is a sample electronic 837 Institutional Inpatient form displaying the Header 1 tab.

The screenshot shows the '837 Institutional Inpatient Claim' window with the 'Header 1' tab selected. The form contains various input fields for billing information, including Total Charge, OI Amount, Billed Amount, and Services. It also includes fields for Billing Provider ID/NPI, Taxonomy Code, Pay-to Provider ID/NPI, Member ID, Account #, and various codes like Encounter Ind, Release of Medical Data, Benefits Assignment, Patient Status, Report Transmission Code, Report Type Code, and Attachment Ctl. A table at the bottom lists Member ID, Last Name, First Name, Billed Amount, Last Submit Dt, and Status. On the right side, there are buttons for Add, Copy, Delete, Undo All, Save, Find..., Print, and Close.

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------



Complete the following fields under the Header 1 tab to submit an Inpatient claim:

Field	Guidelines
Type Of Bill	Choose the best value to indicate the type of bill for this claim.
Original Claim #	If the Type of Bill entered ended with a '7' (replacement) or an '8' (void), you must enter the ICN/TCN for the claim you are adjusting or voiding. For additional information on completing this process, please refer to the Void & Adjustment section of this guide.
Billing Provider ID/NPI	Choose the appropriate billing provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name (Not applicable)	This field is not applicable for Inpatient Claims.
Pay-to Provider ID/NPI	Use if only different than the Billing Provider ID. Choose the appropriate payee provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name (Not applicable)	This field is not applicable for Inpatient Claims.
Member ID	Choose the Member's twelve-digit Medicaid number from your member list. If you have not added the required ID to your list, double-click on this field to do so.
Account #	This field will auto-populate based upon your choice in the Member ID field.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.
MI	This field will auto-populate.
From DOS	Enter the start date of the service billed in a MM/DD/CCYY format.
To DOS	Enter the stop date of the service billed in a MM/DD/CCYY format.
Medical Record # (Optional)	Enter the medical record number, assigned to the member, by the provider, for the service that was performed. This field will accept up to 30 alphanumeric characters. This field is optional.
Encounter Ind	If this claim is an encounter claim, choose the appropriate value. The value



Field	Guidelines
	"CH" will automatically default and should remain as the selected option to be considered for payment.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Patient Status	Enter a valid two-digit code to indicate the patient's discharge status, if discharged.
Report Transmission Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Report Type Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Attachment Ctl	Required if sending a paper attachment separate from the claim. Enter a unique identification code for the attachment that is being sent. This code is alphanumeric and the maximum length allowed is eighty characters. Be sure to document this number, the member ID, and your provider number clearly on the attachment, along with the cover sheet. For more information on attachments, please visit <a href="http://www.mmis.georgia.gov">www.mmis.georgia.gov</a> .

### 7.2.2 Header 2 Tab

Below is a sample electronic 837 Inpatient form displaying the Header 2 tab.



Complete the following fields under the Header 2 tab to submit an Inpatient claim:

Field	Guidelines
Diagnosis Code – Primary	Enter a valid primary diagnosis code. Code should be three to five digits with no decimal point.
Diagnosis Code – Other	If applicable, enter other diagnoses that relate to claim. If entered, Code should be three to five digits with no decimal point.
Diagnosis Code – Admit	Enter a valid admittance diagnosis code. Code should be three to five digits with no decimal point.
Diagnosis – E-Code (External Cause of Injury Code)	Required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment. Enter the diagnosis code which describes the external cause of injury, poisoning or adverse affect. If entered, Code should be three to five digits with no decimal point.
Surgical Codes/ Dates	If applicable, please enter the ICD-9-CM code(s). If a code was entered, enter the surgery date in MM/DD/CCYY format.
Attending Provider ID/NPI	Choose the appropriate attending physician’s license number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field to do so. Enter the license information in the following manner: ME9999999 with no spaces.



Field	Guidelines
Taxonomy Code	This field will auto-populate based on your choice in the Attending Provider ID/NPI field.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.

### 7.2.3 Header 3 Tab

Below is a sample electronic 837 Inpatient form displaying the Header 3 tab.

The screenshot shows the '837 Institutional Inpatient Claim' window with the 'Header 3' tab selected. At the top, there are fields for 'Total Charge', 'OI Amount', 'Billed Amount', and 'Services'. Below this is a tabbed interface with 'Header 1', 'Header 2', 'Header 3' (selected), 'Header 4', 'Header 5', and 'Service'. The 'Header 3' tab contains three main sections: 'Occurrence Codes/Dates' with eight input fields (1-8) for codes and dates; 'Occurrence Span Codes/Dates' with two input fields for span codes and dates; and 'Condition Codes' with seven input fields (1-7) for condition codes. Below these sections are checkboxes for 'Days Covered', 'Non-Covered', 'Coinsurance', and 'Lifetime Reserve'. At the bottom, there is a table with columns: 'Member ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'. On the right side of the form, there are buttons for 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Find...', 'Print', and 'Close'.

Complete the following fields under the Header 3 tab to submit an inpatient claim:

Field	Guidelines
Occurrence Codes/ Dates	If applicable, enter the appropriate occurrence code(s). If a value was entered, enter the occurrence date in MM/DD/CCYY format.
Span Codes/Dates	If applicable, enter the appropriate span codes/date. Date should be entered in MM/DD/CCYY format.
Condition Codes	If applicable, enter the appropriate condition code(s).



Field	Guidelines
Days Covered	Enter the total number of covered days.
Days Non-Covered	Leave blank, unless applicable.
Coinsurance	Leave blank, unless applicable.
Lifetime Reserve	Leave blank, unless applicable.

#### 7.2.4 Header 4 Tab

Below is a sample 837 Inpatient form displaying the Header 4 tab.

The screenshot shows the '837 Institutional Inpatient Claim' window with the 'Header 4' tab selected. At the top, summary fields show 'Total Charge', 'OI Amount', 'Billed Amount', and 'Services' (1). Below the tabs, the 'Value Codes/Amounts' section contains a grid of 12 input fields, each with a value code (1, 4, 7, 10, 2, 5, 8, 11, 3, 6, 9, 12) and a corresponding amount field (all showing .00). The 'Operating Physician' section includes fields for 'Provider ID/NPI', 'Last/Org Name', 'Taxonomy Code', and 'First Name'. At the bottom, a table header lists 'Member ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'. On the right side, a vertical stack of buttons includes 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Find...', 'Print', and 'Close'.

Complete the following fields under the Header 4 tab to submit an Inpatient claim:

Field	Guidelines
Value Codes/Amounts	If applicable, enter the appropriate value code and the corresponding amount in DD.CC format.
Operating Physician Provider ID/NPI	If applicable, choose an operating physician number from the corresponding Provider list. This field is required when a surgical procedure code is listed on the claim. If you have not added the required



Field	Guidelines
	ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Operating Physician ID/NPI field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.

### 7.2.5 Header 5 Tab

Below is a sample 837 Inpatient form displaying the Header 5 tab.

The screenshot shows the '837 Institutional Inpatient Claim' window with the 'Header 5' tab selected. The form includes fields for 'Admission' (Date, Hour, Type), 'Discharge Hour', 'Admit Source', 'Patient Responsibility', 'Prior Auth/Referral Qualifier' (1 and 2), 'Prior Auth/Referral Number' (1 and 2), 'Other Insurance Indicator', and 'Crossover Indicator'. A table at the bottom lists 'Member ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'. On the right side, there are buttons for 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Find...', 'Print', and 'Close'.

Complete the following fields under the Header 5 tab to submit an Inpatient claim:

Field	Guidelines
Admission Date	Enter the date the member was admitted into your facility in MM/DD/CCYY format. Required on GA Medicaid Inpatient & Hospice Claims.



Field	Guidelines
Admission Hour	Indicate the hour of the member's admission.
Admission Type	Choose the appropriate value to indicate the priority of the admission.
Discharge Hour	Indicate the hour of the member's discharge.
Admit Source	Enter the referral source code for this admission.
Patient Responsibility	Hospice Claims only. If applicable, please enter the patient's responsibility.
Prior Auth/Referral Qualifier 1	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Choose the appropriate qualifier from the drop-down menu. (SEE NOTE BELOW)
Prior Auth/Referral Number 1	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this claim. (SEE NOTE BELOW)
Prior Auth/Referral Qualifier 2	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Choose the appropriate qualifier from the drop-down menu. (SEE NOTE BELOW)
Prior Auth/Referral Number 2	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this claim. (SEE NOTE BELOW)
Other Insurance Ind	Choose the best value to indicate whether or not the member has other insurance besides Georgia Medicaid.
Crossover Ind	Choose the best value to indicate if the claim is a crossover from Medicare.

**Note:** If the claim requires the entry of a Referral number and a Prior Authorization number, the Referral qualifier must be selected in the Prior Auth/Referral Qualifier 1 field and the Referral number must be entered in the Prior Auth/Referral Number 1 field; the Prior Authorization qualifier must be selected in the Prior Auth/Referral Qualifier 2 field and the Prior Authorization number must be entered in the Prior Auth/Referral Number 2 field.



## 7.2.6 OI Tab (Other Insurance)

Completing the Other Insurance (OI) tab is required if the indicator in the Other Insurance Ind field was marked as 'Yes' in Header 5. Below is a sample electronic 837 Inpatient form displaying the OI (Other Insurance) tab.

The screenshot shows the '837 Institutional Inpatient Claim' window with the 'OI' tab selected. The window has a title bar with standard Windows controls. Below the title bar, there are summary fields: 'Total Charge' .00, 'OI Amount' .00, 'Billed Amount' .00, and 'Services' 1. A tabbed interface at the top includes 'Header 1', 'Header 2', 'Header 3', 'Header 4', 'Header 5', 'OI' (selected), 'Crossover', and 'Service'. The 'OI' tab contains several fields: 'Release of Medical Data' (dropdown), 'Benefits Assignment' (dropdown with 'Y' selected), 'Claim Filing Ind Code' (dropdown), 'Adjustment Group Cd' (dropdown), and 'Payer Responsibility' (dropdown). Below these are three rows of 'Reason Codes/Amts' with columns for code and amount. The first row shows code '1' and amount '.00'. The second row shows code '2' and amount '.00'. The third row shows code '3' and amount '.00'. There is also a 'Paid Date/Amount' field with a date of '00/00/0000' and an amount of '.00'. A 'Policy Holder' section includes fields for 'Group #', 'Group Name', 'Carrier Code', 'Last Name', and 'First Name'. Below this is a table with columns 'Srv #', 'Carrier Code', 'Group #', 'Group Name', and 'Last Name', containing one row with '1' in the 'Srv #' column. At the bottom, there is a table with columns 'Member ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'. On the right side of the window, there are buttons: 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Find...', 'Print', and 'Close'.

Complete the following fields under the Other Insurance tab to submit an Inpatient claim:

Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Claim Filing Ind Code	Choose the best value to indicate the category of the member's other insurance.
Adjustment Group Cd	Indicate the reason for any unpaid portion of the charges by the other insurance.
Payer Responsibility	Choose the best value to indicate the member's insurance coverage status to Medicaid.



Field	Guidelines
	P Primary S Secondary T Tertiary.
Reason Codes/Amts	If applicable, Enter 1 for deductible, 2 for coinsurance, and the corresponding amounts. Enter in DD.CC format.
Paid Date/Amount	If applicable, enter the date the other insurance paid and the corresponding dollars and cents that were paid towards the service(s) being billed. Enter in a DD.CC format.
Policy Holder Group #	Choose the appropriate Policy Holder Group number from your Policy Holder list. If you have not added the group number to your list, double-click on this field to do so.
Group Name	This field will auto-populate based on the information chosen in the Group Number field.
Carrier Code	This field will auto-populate.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.

#### 7.2.6.1 Adding, Deleting, or Copying another insurance

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more than one insurance at a time if it is applicable to the member.

#### 7.2.7 Crossover Tab

Completing the Crossover tab is required if the indicator in the *Crossover Ind* field was marked as 'Yes' in Header 5. If the claim is Medicare related, this tab allows you to enter the information based on the payment made. Below is a sample 837 Inpatient form displaying the Crossover tab.



837 Institutional Inpatient Claim

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 Header 2 Header 3 Header 4 Header 5 OI **Crossover** Service

Release of Medical Data Y Benefits Assignment Y Claim Filing Ind Code MA

Paid Amount .00 Paid Date 00/00/0000

**Amounts**  
Allowed .00 Deductible .00 Coinsurance .00  
Copay .00 Blood Deductible .00

**Policy Holder**  
Carrier Code  
Last Name First Name

Member ID Last Name First Name Billed Amount Last Submit Dt Status

Add  
Copy  
Delete  
Undo All  
Save  
Find...  
Print  
Close

Complete the following fields under the Crossover tab to submit an Inpatient claim:

Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Claim Filing Ind Code	Choose the best value to indicate the category of the member's other insurance.
Paid Amount	Enter the total amount Medicare paid toward the claim. Enter in DD.CC format.
Paid Date	Enter the date Medicare paid the claim in MM/DD/CCYY format.
Amounts Allowed	Enter the Medicare allowed amount.
Deductible	If applicable, enter the deductible related to the claim.
Coinsurance	If applicable, enter the coinsurance related to the claim.
Policy Holder Carrier	Choose the appropriate code from drop-down menu. If you have not



Field	Guidelines
Code	added the Carrier Code to your list, double-click on this field to do so.
Last Name	This field will auto-populate based on the information chosen in the Carrier Code field.
First Name	This field will auto-populate.

### 7.2.8 Service Tab

Below is a sample 837 Inpatient form displaying the Service 1 tab.

**837 Institutional Inpatient Claim**

Total Charge: .00 OI Amount: .00 Billed Amount: .00 Services: 1

Header 1 | Header 2 | Header 3 | Header 4 | Header 5 | OI | Crossover | **Service**

Revenue Code:  Unit Rate: .00

Basis of Measurement: UN Units: .00

Billed Amount: .00 Non-Covered Charge: .00

RX Ind: N Procedure:

Add Srv Copy Srv Delete Srv

Srv #	Revenue Code	Units	Billed Amount
1		.00	0.00

Member ID | Last Name | First Name | Billed Amount | Last Submit Dt | Status

Find... Print Close

Complete the following fields under the Service 1 tab to submit an Inpatient claim:

Field	Guidelines
Revenue Code	Choose a revenue code from the revenue code list. If you would like to add Revenue Codes to your list, double-click on this field to do so.
Unit Rate	If applicable, enter the appropriate rate.
Basis of Measurement	Choose appropriate measurement for services provided.
Units	Enter the unit(s) billed for the service.



Field	Guidelines
Billed Amount	Enter the amount billed for the service. Enter in DD.CC format.
Non-Covered Charge	Enter the non covered amount. This field is optional.
RX Indicator	If the procedure you are billing requires a NDC (National Drug Code) according to Georgia Medicaid Policy, please choose yes and complete the RX tab before adding any additional line items.

### 7.2.8.1 Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

### 7.2.9 RX Tab

Below is a sample electronic 837I Inpatient form displaying the RX tab.

837 Institutional Inpatient Claim

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 Header 2 Header 3 Header 4 Header 5 OI Crossover Service **RX**

Pharmaceutical

NDC

Quantity 0.000 Unit Price .00 Unit of Measurement

Add RX Copy RX Delete RX

RX #	NDC	Quantity	Unit of Measurement	Unit Price
1		0.000		.00

Member ID Last Name First Name Billed Amount Last Submit Dt Status

Add Copy Delete Undo All Save Find... Print Close

Complete the following fields under the RX tab to submit an 837I Inpatient claim:

Field	Guidelines
Pharmaceutical	Choose an NDC code from your NDC list to indicate which applies to this service. If you have not added the required NDC to your list, double-click on



Field	Guidelines
NDC	this field to do so.
Quantity	Enter the quantity of the drug indicated by the NDC that is being billed.
Unit Price	Enter the cost per unit of the NDC indicated that is billed to the patient. Leave as ".00" if the price per unit is unknown.
Unit of Measurement	Select the unit that was used for measuring the quantity of the NDC.

#### 7.2.9.1 Adding, Deleting, or Copying a Prescription (RX)

Use the buttons to the left of the form to add, delete, or copy an RX. Once you copy an RX, you can modify it as necessary.

After completing all necessary fields and reviewing entered data for accuracy, press Save to add your claim to the Claim List.

#### 7.2.9.2 To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

1. Key over incorrect data on the claim form. ***You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete).*** Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
2. Press 'Copy' to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different members). Modify the new record accordingly. Save the new record.
3. Press 'Delete' to delete an unwanted record.

#### 7.2.9.3 Submitting Voids/Adjustments to a Paid Claim ( if claim you wish to Void/Adjust is in your claim list)

1. Find the Claim you wish to Void/Adjust from the Institutional Inpatient List. Press Copy.
2. In the Type of Bill field, select the appropriate code to inform Medicaid if the request is an Adjustment/Replacement or a Void. Select the appropriate Type of Bill ending in a '7' for an adjustment or an '8' for a void.

#### CLAIM FREQUENCY:

- a. 7 - (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously created claim.



- b. 8 - (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim
3. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim was accepted and paid. This information can be located on your *Remittance Advice*.
  - a. If the value '7' was chosen, make any necessary corrections/adjustments to the current claim.
  - b. If the value '8' was chosen, please continue with Step 4.
4. Press 'Save' to save your claim, and follow Section 7.3 Submitting Claims through the Web Server.

**Note:** To adjust or void a paid claim, wait until you have received your Remittance Advice listing the paid claim's ICN/TCN.

#### 7.2.9.4 Submitting Voids/Adjustments to a Paid Claim (if claim you wish to Void/Adjust is NOT in your claim list)

1. Enter your claim as you normally would, complete all necessary fields.
2. In the Type of Bill field, select the appropriate code to inform Medicaid if the request is an Adjustment/Replacement or a Void. Select the appropriate Type of Bill ending in a '7' for an adjustment or an '8' for a void.

#### **CLAIM FREQUENCY:**

- a. 7 - (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously created claim.
  - b. 8 - (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.
3. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim was accepted and paid. This information can be located on your *Remittance Advice*.
  - a. If the value '7' was chosen, make any necessary corrections/adjustments to the current claim.
  - b. If the value '8' was chosen, please continue with Step 4.
4. Press 'Save' to save your claim, and follow Section 7.3 Submitting Claims through the Web Server.

**Note:** To adjust or void a paid claim, wait until you have received your Remittance Advice listing the paid claim's ICN/TCN.



### 7.3 Submitting Claims through the Web Server

Select Communication>>Submission to display the Batch Submission window, pictured below:

The screenshot shows the 'Batch Submission' window with the 'Submission' tab selected. The 'Method' is set to 'Web Server'. There are two main sections: 'Files To Send' and 'Files To Receive'. The 'Files To Send' list contains five items: 837 Dental, 837 Institutional Inpatient, 837 Institutional Nursing Home, 837 Institutional Outpatient, and 837 Professional. The 'Files To Receive' list contains one item: 824 Claim Acknowledgement(s). There are 'Select All' and 'Deselect All' buttons for each list. At the bottom right are 'Submit' and 'Close' buttons.

1. Determine which files you want to send from the Files to Send list. Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.
2. Determine which files you want to receive from the Files to Receive list. Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.
3. Press 'Submit' to send and/or receive files. Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.
4. After submission, follow Steps 1-3 to receive the response from the Web Server.

Refer to "Receiving a Response" on page 10-1, for information about receiving responses, resubmitting files, and reviewing submission reports.


**Note:** When you submit batch transactions, you must wait a period of time (fifteen minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files, remember you are *receiving responses for any previous transmission where you have not already retrieved a response file, not the current transmission.*



## 8 Submitting 837 Institutional Outpatient Claims

This chapter provides instructions for submitting electronic 837 outpatient claims. Please note this user manual does not discuss program requirements. Refer to the Georgia Medicaid Provider Manual for program-specific information.

Users access the electronic 837 Institutional Outpatient claim form using one of the following methods:

1. Selecting the 837 Institutional Outpatient icon from the toolbar 
2. Selecting Forms>>837 Institutional Outpatient

The electronic form displays with four tabs: Header 1, Header 2, Header 3, and Service. The additional tabs, if applicable, are: OI (Other Insurance), Crossover, and RX.

### 8.1 Entering Claims in the 837 Institutional Outpatient Form

Each tab on the 837 Institutional Outpatient form contains four main parts:

1. Header line of fields that contain provider and member information.
2. Updateable fields used to enter claims data.
3. Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
4. Lists fields at the bottom of the form that enable users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Member ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	Usage
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different members, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.



Button	Usage
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or member ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

#### 8.1.1 To Add a New Claim

1. Access the 837 Institutional Outpatient form. Key information into all required fields. Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.
2. Press the 'Save' button to save the record. The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.
3. Correct each mistake and press 'Save', or press Incomplete to save the record with an incomplete status. Incomplete claims (status 'I') are not submitted with the batch submission.
4. Press the 'Add' button to add another claim.

#### 8.1.2 To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

1. Key over incorrect data on the claim form. You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete). Save the changes. Press Undo All if you inadvertently overwrite a correct claim.
2. Press 'Copy' to copy a claim that closely matches the information you need to enter (for instance, if you must enter claims for identical services, but different members) and modify the new record accordingly. Save the new record.
3. Press 'Delete' to delete an unwanted record.

#### 8.1.3 To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:



1. Find Where (select a field from the drop-down list, if applicable)
2. Find What (enter your search criteria here)
3. Search (select up or down from the drop-down list)
4. Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.
5. Press 'Cancel' when you have finished searching.

## 8.2 837 Institutional Outpatient Form

### 8.2.1 Header 1 Tab

Below is a sample electronic 837 Institutional Outpatient form displaying the Header 1 tab.

The screenshot shows the '837 Institutional Outpatient Claim' window with the 'Header 1' tab selected. The form contains several input fields and buttons. At the top, there are summary fields: 'Total Charge' (0.00), 'OI Amount' (.00), 'Billed Amount' (.00), and 'Services' (1). Below these are tabs for 'Header 1', 'Header 2', 'Header 3', 'Header 4', 'Header 5', and 'Service'. The 'Header 1' tab contains fields for 'Type Of Bill' (dropdown), 'Original Claim #' (text), 'Billing Provider ID/NPI' (text), 'Taxonomy Code' (text), 'Last/Org Name' (text), 'First Name' (text), 'Pay-to Provider ID/NPI' (text), 'Taxonomy Code' (text), 'Last/Org Name' (text), 'First Name' (text), 'Member ID' (text), 'Account #' (text), 'Last Name' (text), 'First Name' (text), 'MI' (text), 'From DOS' (00/00/0000), 'To DOS' (00/00/0000), 'Medical Record #' (text), 'Encounter Ind' (CH), 'Contract Type' (dropdown), 'Release of Medical Data' (Y), 'Benefits Assignment' (Y), 'Patient Status' (dropdown), 'Report Transmission Code' (dropdown), 'Report Type Code' (dropdown), and 'Attachment Ctl' (text). On the right side of the form, there are buttons: 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Find...', 'Print', and 'Close'. At the bottom, there is a table with columns: 'Member ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'.

Complete the following fields under the Header 1 tab to submit an Outpatient claim:

Field	Guidelines
Type Of Bill	Choose the best value to indicate the type of bill for this claim.



Field	Guidelines
Original Claim #	If the Type of Bill entered ended with a '7' (replacement) or an '8' (void), you must enter the ICN/TCN for the claim you are adjusting or voiding. For additional information on completing this process, please refer to the Void & Adjustment section of this guide.
Billing Provider ID/NPI	Choose the appropriate billing provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Pay-to Provider ID/NPI	Use if only different than the Billing Provider ID. Choose the appropriate payee provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Member ID	Choose the member's twelve-digit Medicaid number from your member list. If you have not added the required ID to your list, double-click on this field to do so.
Account #	This field will auto-populate based upon your choice in the Member ID field.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.
MI	This field will auto-populate.
From DOS	Enter the start date of the service billed in a MM/DD/CCYY format.
To DOS	Enter the stop date of the service billed in a MM/DD/CCYY format.
Medical Record # (Optional)	Enter the medical record number, assigned to the member, by the provider, for the service that was performed. This field will accept up to thirty alphanumeric characters. This field is optional.
Encounter Ind	If this claim is an encounter claim, choose the appropriate value. The value "CH" will automatically default and should remain as the selected option to be considered for payment.
Contract Type	Not applicable for Outpatient claims.
Release of	Choose a value to indicate whether the provider has on file a signed statement



Field	Guidelines
Medical Data	by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Patient Status	Enter a valid two-digit code to indicate the patient's discharge status. Not required for Freestanding Dialysis Centers.
Report Transmission Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Report Type Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Attachment Ctl	Required if sending a paper attachment separate from the claim. Enter a unique identification code for the attachment that is being sent. This code is alphanumeric and the maximum length allowed is 80 characters. Be sure to document this number, the member ID, and your provider number clearly on the attachment, along with the cover sheet. For more information on attachments, please visit <a href="http://www.mmis.georgia.gov">www.mmis.georgia.gov</a> .

### 8.2.2 Header 2 Tab

Below is a sample electronic 837 Outpatient form displaying the Header 2 tab.

The screenshot shows the '837 Institutional Outpatient Claim' window with the 'Header 2' tab selected. The window title bar includes standard minimize, maximize, and close buttons. The main area contains several sections of data entry fields:

- Total Charge:** 0.00
- OI Amount:** .00
- Billed Amount:** .00
- Services:** 1

Below these are tabs for Header 1, Header 2 (selected), Header 3, Header 4, Header 5, and Service.

**Diagnosis Codes:**

- Primary:** [Empty field]
- Other:** 1 [Empty], 2 [Empty], 3 [Empty], 4 [Empty], 5 [Empty], 6 [Empty], 7 [Empty], 8 [Empty]
- Admit:** [Empty]
- E-Code:** [Empty]

**Surgical Procedure Codes/Dates:**

- 1 [Empty] [00/00/0000], 2 [Empty] [00/00/0000], 3 [Empty] [00/00/0000], 4 [Empty] [00/00/0000], 5 [Empty] [00/00/0000], 6 [Empty] [00/00/0000]

**Attending:**

- Provider ID/NPI:** [Empty]
- Taxonomy Code:** [Empty]
- Last/Org Name:** [Empty]
- First Name:** [Empty]

At the bottom is a table header with columns: Member ID, Last Name, First Name, Billed Amount, Last Submit Dt, and Status.

On the right side of the form are several buttons: Add, Copy, Delete, Undo All, Save, Find..., Print, and Close.



Complete the following fields under the Header 2 tab to submit an Outpatient claim:

Field	Guidelines
Diagnosis Code – Primary	Enter a valid primary diagnosis code. Code should be three to five digits with no decimal point.
Diagnosis Code – Other	If applicable, enter other diagnoses that relate to claim. If entered, this code should be three to five digits with no decimal point.
Diagnosis – E-Code (External Cause of Injury Code)	Required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment. Enter the diagnosis code which describes the external cause of injury, poisoning or adverse affect. If entered, this code should be three to five digits with no decimal point.
Surgical Procedure Codes/Dates	If applicable, please enter the ICD-9-CM code(s). If a code was entered, enter the surgery date in MM/DD/CCYY format.
Attending Provider ID/ NPI	Choose the appropriate attending physician's license number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field to do so. Enter the license information in the following manner: ME99999999 with no spaces.
Taxonomy Code	This field will auto-populate based on your choice in the Attending Provider ID/NPI field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.



## 8.2.3 Header 3 Tab

Below is a sample electronic 837 Outpatient form displaying the Header 3 tab.

837 Institutional Outpatient Claim

Total Charge 0.00 OI Amount .00 Billed Amount .00 Services 1

Header 1 Header 2 **Header 3** Header 4 Header 5 Service

**Occurrence Codes/Dates**

1	00/00/0000	2	00/00/0000	3	00/00/0000
4	00/00/0000	5	00/00/0000	6	00/00/0000
7	00/00/0000	8	00/00/0000		

**Occurrence Span Codes/Dates**

1	00/00/0000	00/00/0000
2	00/00/0000	00/00/0000

**Condition Codes**

1		2		3	
4		5		6	
7					

**Days**

Covered  Non-Covered  Coinsurance  Lifetime Reserve

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------

Find...  
Print  
Close

Add  
Copy  
Delete  
Undo All  
Save

Complete the following fields under the Header 3 tab to submit an Outpatient claim:

Field	Guidelines
Occurrence Codes/ Dates	If applicable, enter the appropriate occurrence code(s). If a value was entered, enter the occurrence date in MM/DD/CCYY format.
Span Codes/Dates	If applicable, enter the appropriate span code/dates. Date should be entered in MM/DD/CCYY format.
Condition Codes	If applicable, enter the appropriate condition code(s).
Days Covered	Enter the total number of covered days.
Days Non-Covered	Not applicable for Outpatient claims.
Coinsurance	Leave blank, unless applicable.
Lifetime Reserve	Leave blank, unless applicable.



## 8.2.4 Header 4 Tab

Below is a sample 837 Outpatient form displaying the Header 4 tab.

837 Institutional Outpatient Claim

Total Charge 0.00 OI Amount .00 Billed Amount .00 Services 1

Header 1 Header 2 Header 3 **Header 4** Header5 Service

**Value Codes/Amounts**

1		.00	2		.00	3		.00
4		.00	5		.00	6		.00
7		.00	8		.00	9		.00
10		.00	11		.00	12		.00

**Operating Physician**  
Provider ID/NPI  
Taxonomy Code  
Last/Org Name  
First Name

**Other Physician**  
Provider ID/NPI  
Taxonomy Code  
Last/Org Name  
First Name

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------

Add  
Copy  
Delete  
Undo All  
Save  
Find...  
Print  
Close

Complete the following fields under the Header 4 tab to submit an Outpatient claim:

Field	Guidelines
Value Codes/Amounts	If applicable, enter the appropriate value code and the corresponding amount in DD.CC format.
Operating Physician Provider ID/NPI	If applicable, choose an operating physician number from the corresponding Provider list. This field is required when a surgical procedure code is listed on the claim. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Operating Physician ID/NPI field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Other Physician Provider ID/NPI	If applicable, choose another physician number from the corresponding Provider list. This field is required when the referring provider is different than the attending physician, report the referring physician's information. If you have not added the required ID to your list, double-click on this field to do so.



Field	Guidelines
Taxonomy Code	This field will auto-populate based on your choice in the Other Physician ID/NPI field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.

### 8.2.5 Header 5 Tab

Below is a sample 837 Outpatient form displaying the Header 5 tab.

**837 Institutional Outpatient Claim**

Total Charge: 0.00 OI Amount: .00 Billed Amount: .00 Services: 1

Header 1 | Header 2 | Header 3 | Header 4 | **Header 5** | Service

Patient Responsibility: .00 Discharge Hour: [Dropdown]

Admit Date: 00/00/0000 Admit Hour: [Dropdown] Admit Type: [Dropdown]

Prior Auth/Referral Qualifier: 1 [Dropdown] Prior Auth/Referral Number: 1 [Text Box]

Prior Auth/Referral Qualifier: 2 [Dropdown] Prior Auth/Referral Number: 2 [Text Box]

Other Insurance Indicator: N Crossover Indicator: N

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status

Find... Print Close

Complete the following fields under the Header 5 tab to submit an Outpatient claim:

Field	Guidelines
Patient Liability	Not applicable for Outpatient Claims.
Prior Auth/Referral Qualifier 1	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Choose the appropriate qualifier from the drop-down menu. (SEE NOTE BELOW)
Prior Auth/Referral Number 1	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this



Field	Guidelines
	claim. (SEE NOTE BELOW)
Prior Auth/Referral Qualifier 2	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Choose the appropriate qualifier from the drop-down menu. (SEE NOTE BELOW)
Prior Auth/Referral Number 2	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this claim. (SEE NOTE BELOW)
Other Insurance Ind	Choose the best value to indicate whether or not the member has other insurance besides Georgia Medicaid.
Crossover Ind	Choose the best value to indicate if the claim is a crossover from Medicare.

**Note:** If the claim requires the entry of a Referral number and a Prior Authorization number, the Referral qualifier must be selected in the Prior Auth/Referral Qualifier 1 field and the Referral number must be entered in the Prior Auth/Referral Number 1 field; the Prior Authorization qualifier must be selected in the Prior Auth/Referral Qualifier 2 field and the Prior Authorization number must be entered in the Prior Auth/Referral Number 2 field.

#### 8.2.6 OI Tab (Other Insurance)

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes' in Header 5. Below is a sample electronic 837 Outpatient form displaying the OI (Other Insurance) tab.



837 Institutional Outpatient Claim

Total Charge 0.00 OI Amount .00 Billed Amount .00 Services 1

Header 1 Header 2 Header 3 Header 4 Header 5 OI Service

Release of Medical Data Benefits Assignment Y

Claim Filing Ind Code Payer Responsibility

Paid Amount .00

Policy Holder

Group # Group Name Carrier Code

Last Name First Name

Srv #	Carrier Code	Group #	Group Name	Last Name
1				

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------

Find... Print Close

Complete the following fields under the Other Insurance tab to submit an Outpatient claim:

Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Claim Filing Ind Code	Choose the best value to indicate the category of the member's other insurance.
Payer Responsibility	Choose the best value to indicate the member's insurance coverage status to Medicaid. P = Primary; S = Secondary; T = Tertiary
Paid Amount	Enter the dollars and cents that were paid towards the service(s) being billed. Enter in a DD.CC format.
Policy Holder Group #	Choose the appropriate Policy Holder Group number from your Policy Holder list. If you have not added the group number to your list, double-click on this field to do so.
Group Name	This field will auto-populate based on the information chosen in the Group



Field	Guidelines
	Number field.
Carrier Code	This field will auto-populate.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.

#### 8.2.6.1 Adding, Deleting, or Copying Another Insurance

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more than one insurance at a time if it is applicable to the member.

#### 8.2.7 Crossover Tab

Completing the Crossover tab is required if an indicator in the *Crossover Ind* field was marked as 'Yes' in Header 5. If the claim is Medicare related, this tab allows you to enter the information based on the payment or non-payment made. Below is a sample 837 Outpatient form displaying the Crossover tab.

The screenshot shows the '837 Institutional Outpatient Claim' window with the 'Crossover' tab selected. The window title bar includes standard minimize, maximize, and close buttons. The top status bar displays 'Total Charge 0.00', 'OI Amount .00', 'Billed Amount .00', and 'Services 1'. Below this is a tabbed interface with 'Header 1', 'Header 2', 'Header 3', 'Header 4', 'Header 5', 'OI', 'Crossover', and 'Service'. The 'Crossover' tab contains the following fields and controls:

- Release of Medical Data:** A dropdown menu with 'Y' selected.
- Benefits Assignment:** A dropdown menu with 'Y' selected.
- Claim Filing Ind Code:** A dropdown menu with 'MB' selected.
- Paid Amount:** A text input field with '.00' entered.
- Paid Date:** A date input field with '00/00/0000' entered.
- Policy Holder:** A section containing:
  - Carrier Code:** An empty text input field.
  - Last Name:** An empty text input field.
  - First Name:** An empty text input field.

On the right side of the form, there is a vertical stack of buttons: 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Find...', 'Print', and 'Close'. At the bottom of the window, there is a table with the following columns: 'Member ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'.



Complete the following fields under the Crossover tab to submit an Outpatient claim:

Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Claim Filing Ind Code	Choose the best value to indicate the category of the member's other insurance. Ex: CI: Commercial Insurance Co.
Paid Amount	Enter the total amount Medicare paid toward the claim. Enter in DD.CC format.
Policy Holder Carrier Code	Choose the appropriate code from drop-down menu. If you have not added the Carrier Code to your list, double-click on this field to do so.
Last Name	This field will auto-populate based on the information chosen in the Carrier Code field.
First Name	This field will auto-populate.

#### 8.2.8 Service Tab

Below is a sample 837 Outpatient form displaying the Service tab:



837 Institutional Outpatient Claim

Total Charge 0.00 OI Amount .00 Billed Amount .00 Services 1

Header 2 Header 3 Header 4 Header5 OI Crossover Service Service 2

Date Of Service 00/00/0000 Revenue Code Billed Amount .00

Units .00 Basis of Measurement UN Unit Rate .00

Procedure Modifiers: 1 2 3 4

Non-Covered Charge .00 RX Ind N

Service Adjustment Ind Y

Add Srv Copy Srv Delete Srv

Srv #	Date Of Service	Revenue Code	Units	Billed Amount
1			.00	.00

Member ID Last Name First Name Billed Amount Last Submit Dt Status

Find... Print Close

Complete the following fields under the Service 1 tab to submit an Outpatient claim:

Field	Guidelines
Date of Service	Enter the date of service for each procedure provided in a MM/DD/CCYY format.
Revenue Code	Choose a revenue code from the revenue code list. If you would like to add Revenue Codes to your list, double-click on this field to do so.
Billed Amount	Enter the amount billed for the service. Enter in DD.CC format.
Units	Enter the unit(s) billed for the service.
Basis of Measurement	Choose appropriate measurement for services provided.
Unit Rate	If applicable, enter the appropriate rate.
Procedure	If applicable, enter the appropriate five-digit procedure code for each procedure or service billed.
Modifiers	If applicable, enter the modifier(s) for the procedure.
Non-Covered Charge	If applicable, enter the non-covered amount.
Rx Indicator	If the procedure you are billing requires a NDC (National Drug Code) according to Georgia Medicaid Policy, please choose yes and complete



Field	Guidelines
	the RX tab before adding any additional line items.
Service Adjustment Indicator	If applicable, choose the best value to acknowledge "Other Insurance (OI)" adjudication.

If the *Service Adjustment Indicator* field was marked as "Yes," click on and complete the Service 2 tab.

#### 8.2.8.1 Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

After completing all necessary fields under the Service tab, review your claim and press Save.

#### 8.2.9 Service Tab 2 on the 837I Outpatient

Below is a sample electronic 837I Outpatient form displaying the Service 2 tab:

The screenshot shows the '837 Institutional Outpatient Claim' window with the 'Service 2' tab selected. The top status bar displays 'Total Charge 0.00 OI Amount .00 Billed Amount .00 Services 1'. The tab bar includes 'Header 2', 'Header 3', 'Header 4', 'Header5', 'OI', 'Crossover', 'Service', and 'Service 2'. The main form area contains the following fields:

- Adjustment Group Cd**: A dropdown menu.
- Reason Codes/Amts:** A table with two rows and two columns. The first row shows '1' and '.00'. The second row shows '2' and '.00'.
- Paid Date/Amount**: A table with two rows and two columns. The first row shows '00/00/0000' and '.00'. The second row shows '3' and '.00'.
- Carrier**: A section with a **Code** dropdown and a **Name** text field.

On the right side of the form, there is a vertical stack of buttons: **Add**, **Copy**, **Delete**, **Undo All**, **Save**, **Find...**, **Print**, and **Close**.

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------



Complete the following fields under the Service 2 tab to submit an 837I Outpatient claim:

Field	Guidelines
Adjustment Group Cd	Choose the best value.
Reason Codes/Amts	If applicable, choose the appropriate code and then enter the corresponding amount in DD.CC format.
Paid Date/Amount	If applicable, enter the date the other insurance paid and the corresponding dollars and cents that were paid towards the service(s) being billed. Enter in a DD.CC format.
Carrier Code	Choose the appropriate Carrier Code from your Carrier list. If you have not added the carrier to your list, double-click on this field to do so.
Carrier Name	This field will auto-populate.

#### 8.2.10 RX Tab

Completing the RX tab is required if an indicator in the *Rx Ind* field was marked as 'Yes'. If the claim requires an NDC, this tab will allow you to enter the appropriate information. Below is a sample 837 Outpatient form displaying the RX tab.

The screenshot shows the '837 Institutional Outpatient Claim' window with the 'RX' tab selected. The window title bar includes standard Windows controls. The top status bar displays 'Total Charge 0.00', 'OI Amount .00', 'Billed Amount .00', and 'Services 1'. Below this is a tabbed interface with 'Header 3', 'Header 4', 'Header5', 'OI', 'Crossover', 'Service', 'Service 2', and 'RX'. The 'RX' tab contains a 'Pharmaceutical' section with fields for 'NDC' (empty), 'Quantity' (0.000), 'Unit Price' (.00), and 'Unit of Measurement' (dropdown). To the right of this section are buttons: 'Add', 'Copy', 'Delete', 'Undo All', and 'Save'. Below the pharmaceutical section is a table with columns: 'RX #', 'NDC', 'Quantity', 'Unit of Measurement', and 'Unit Price'. The first row shows '1' in the 'RX #' column and '0' in the 'Unit Price' column. To the left of this table are buttons: 'Add RX', 'Copy RX', and 'Delete RX'. At the bottom of the window is a summary table with columns: 'Member ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'. To the right of this table are buttons: 'Find...', 'Print', and 'Close'.



Field	Guidelines
Pharmaceutical NDC	Choose an NDC code from your NDC list to indicate which applies to this service. If you have not added the required NDC to your list, double-click on this field to do so.
Quantity	Enter the quantity of the drug indicated by the NDC that is being billed.
Unit Price	Enter the cost per unit of the NDC indicated that is billed to the patient. Leave as ".00" if the price per unit is unknown.
Unit of Measurement	Select the unit that was used for measuring the quantity of the NDC.

#### 8.2.10.1 Adding, Deleting, or Copying a RX

Use the buttons to the left of the form to add, delete, or copy an RX. Once you copy an RX, you can modify it as necessary.

After completing all necessary fields and reviewing entered data for accuracy, **press Save** to add your claim to the Claim List.

#### 8.2.10.2 To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

1. Key over incorrect data on the claim form. ***You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete).*** Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
2. Press 'Copy' to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different members). Modify the new record accordingly. Save the new record.
3. Press 'Delete' to delete an unwanted record.

#### 8.2.10.3 Submitting Voids/Adjustments to a Paid Claim (if claim you wish to Void/Adjust is in Your Claim List)

1. Find the Claim you wish to Void/Adjust from the Institutional Outpatient List. Press Copy
2. In the Type of Bill field, select the appropriate code to inform Medicaid if the request is an Adjustment/Replacement or a Void. Select the appropriate Type of Bill ending in a **'7'** for an adjustment or an **'8'** for a void.



**CLAIM FREQUENCY:**

- a. 7 - (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously created claim.
  - b. 8 - (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.
3. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim was accepted and paid. This information can be located on your *Remittance Advice*.
  - a. If the value '7' was chosen, make any necessary corrections/adjustments to the current claim.
  - b. If the value '8' was chosen, please continue with Step 4.
4. Press 'Save' to save your claim, and follow Section 8.3 Submitting Claims through the Web Server.

**Note:** To adjust or void a paid claim, wait until you have received your Remittance Advice listing the paid claim's ICN/TCN.

8.2.10.4 Submitting Voids/Adjustments to a Paid Claim (if claim you wish to Void/Adjust is NOT in your claim list)

1. Enter your claim as you normally would, complete all necessary fields.
2. In the Type of Bill field, select the appropriate code to inform Medicaid if the request is an Adjustment/Replacement or a Void. Select the appropriate Type of Bill ending in a **'7'** for an adjustment or an **'8'** for a void.

**CLAIM FREQUENCY:**

- a. 7 - (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously created claim.
  - b. 8 - (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.
3. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim was accepted and paid. This information can be located on your *Remittance Advice*.
  - a. If the value '7' was chosen, make any necessary corrections/adjustments to the current claim.
  - b. If the value '8' was chosen, please continue with Step 4.



4. Press 'Save' to save your claim, and follow Section 8.3 Submitting Claims through the Web Server.

**Note:** To adjust or void a paid claim, wait until you have received your Remittance Advice listing the paid claim's ICN/TCN.

### 8.3 Submitting Claims through the Web Server

Select Communication>>Submission to display the Batch Submission window, pictured below:

The screenshot shows the 'Batch Submission' window with the 'Submission' tab selected. The 'Method' is set to 'Web Server'. There are two main sections: 'Files To Send' and 'Files To Receive'. The 'Files To Send' list includes 837 Dental, 837 Institutional Inpatient, 837 Institutional Nursing Home, 837 Institutional Outpatient, and 837 Professional. The 'Files To Receive' list includes 824 Claim Acknowledgement(s). Buttons for 'Select All' and 'Deselect All' are provided for both lists. A 'Submit' button is located to the right of the 'Files To Receive' list, and a 'Close' button is at the bottom right.

1. Determine which files you want to send from the Files to Send list. Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.
2. Determine which files you want to receive from the Files to Receive list. Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.
3. Press 'Submit' to send and/or receive files. Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.
4. After submission, follow Steps 1-3 to receive the response from the Web Server.

Refer to "Receiving a Response" on page 133, for information about receiving responses, resubmitting files, and reviewing submission reports.




**Note:** When you submit batch transactions, you must wait a period of time (fifteen minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files, remember you are *receiving responses for any previous transmission where you have not already retrieved a response file, not the current transmission.*



## 9 Submitting 837 Institutional Nursing Home Claims

This chapter provides instructions for submitting electronic 837 nursing home claims. Please note this user manual does not discuss program requirements. Refer to the Georgia Medicaid Provider Handbooks for program-specific information

Users access the electronic 837 Institutional Nursing Home claim form using one of the following methods:

1. Selecting the 837 Institutional Nursing Home icon from the toolbar 
2. Selecting Forms>>837 Institutional Nursing Home

The electronic form display's with five tabs: Header 1, Header 2, Header 3, Header 4, and Service. The additional tabs, if applicable, are: OI (Other Insurance) and Crossover.

### 9.1 Entering Claims in the 837 Institutional Nursing Home Form

Each tab on the 837 Institutional Nursing Home form contains four main parts:

1. Header line of fields that contain provider and member information.
2. Updateable fields used to enter claims data.
3. Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
4. List fields at the bottom of the form that enables users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Member ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	Usage
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different members, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.



Button	Usage
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or member ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

#### 9.1.1 To Add a New Claim

1. Access the 837 Institutional Nursing Home form. Key information into all required fields. Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.
2. Press the 'Save' button to save the record. The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.
3. Correct each mistake and press 'Save', or press 'Incomplete' to save the record with an incomplete status. Incomplete claims (status 'I') are not submitted with the batch submission.
4. Press the 'Add' button to add another claim.

#### 9.1.2 To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

1. Key over incorrect data on the claim form. You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete). Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
2. Press 'Copy' to copy a claim that closely matches the information you need to enter (for instance, if you must enter claims for identical services, but different members) and modify the new record accordingly. Save the new record.
3. Press 'Delete' to delete an unwanted record.

#### 9.1.3 To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:



1. Find Where (select a field from the drop-down list, if applicable)
2. Find What (enter your search criteria here)
3. Search (select up or down from the drop-down list)

Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

## 9.2 837 Institutional Nursing Home Form

### 9.2.1 Header 1 Tab

Below is a sample electronic 837 Institutional Nursing Home form displaying the Header 1 tab.

The screenshot shows the '837 Institutional Nursing Home Claim' window with the 'Header 1' tab selected. The form contains several input fields and buttons. At the top, there are summary fields: 'Total Charge' (0.00), 'OI Amount' (0.00), 'Billed Amount' (0.00), and 'Services' (1). Below these are tabs for 'Header 1', 'Header 2', 'Header 3', 'Header 4', and 'Service'. The 'Header 1' tab contains the following fields: 'Type Of Bill' (dropdown), 'Original Claim #' (text), 'Billing Provider ID/NPI' (text), 'Taxonomy Code' (text), 'Last/Org Name' (text), 'First Name' (text), 'Pay-to Provider ID/NPI' (text), 'Taxonomy Code' (text), 'Last/Org Name' (text), 'First Name' (text), 'Member ID' (text), 'Account #' (text), 'Last Name' (text), 'First Name' (text), 'MI' (text), 'Encounter Ind' (dropdown, set to 'CH'), 'Contract Type' (dropdown), 'Medical Record #' (text), 'Level of Care' (dropdown), 'Per Diem Rate' (text, set to '.00'), 'Patient Status' (dropdown), 'Release of Medical Data' (dropdown, set to 'Y'), 'Benefits Assignment' (dropdown, set to 'Y'), 'Report Transmission Code' (dropdown), 'Report Type Code' (dropdown), and 'Attachment Ctl' (text). On the right side of the form are buttons: 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Edit All', 'Find...', 'Print', and 'Close'. At the bottom, there is a table with columns: 'Member ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'.

Complete the following fields under the Header 1 tab to submit a Nursing Home claim:

Field	Guidelines
Type Of Bill	Choose the best values to indicate the type of bill for this claim.



Field	Guidelines
Original Claim #	If the Type of Bill entered ended with a '7' (replacement) or an '8' (void), you must enter the ICN/TCN for the claim you are adjusting or voiding. For additional information on completing this process, please refer to the Void & Adjustment section of this guide.
Billing Provider ID/NPI	Choose the appropriate billing provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Pay-to Provider ID/NPI	Use if only different than the Billing Provider ID. Choose the appropriate payee provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Member ID	Choose the Member's twelve-digit Medicaid number from your member list. If you have not added the required ID to your list, double-click on this field to do so.
Account #	This field will auto-populate based upon your choice in the Member ID field.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.
MI	This field will auto-populate.
Encounter Ind	If this claim is an encounter claim, choose the appropriate value. The value "CH" will automatically default and should remain as the selected option to be considered for payment.
Contract Type	Choose the best value to indicate contract type.
Medical Record # (Optional)	Enter the medical record number, assigned to the member, by the provider, for the service that was performed. This field will accept up to thirty alphanumeric characters. This field is optional.
Level of Care	Choose a value to indicate the level of care provided to the member.
Patient Status	Required if the patient has been discharged. Choose a proper code to



Field	Guidelines
	indicate the patient's discharge status as of the end date of your billing period.
Per Diem Rate	
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Report Transmission Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Report Type Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Attachment Ctl	Required if sending a paper attachment separate from the claim. Enter a unique identification code for the attachment that is being sent. This code is alphanumeric and the maximum length allowed is eighty characters. Be sure to document this number, the member ID, and your provider number clearly on the attachment, along with the cover sheet. For more information on attachments, please visit <a href="http://www.mmis.georgia.gov">www.mmis.georgia.gov</a> .

### 9.2.2 Header 2 Tab

Below is a sample electronic 837 Nursing Home form displaying the Header 2 tab.



837 Institutional Nursing Home Claim

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 Header 2 Header 3 Header 4 Service

Admission  
Date 00/00/0000 Hour Type

From DOS 00/00/0000 To DOS 00/00/0000 Admit Source

Discharge Hour

Days  
Covered Non-Covered Coinsurance Lifetime Reserve

Attending  
Provider ID/NPI Taxonomy Code  
Last/Org Name First Name

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------

Find...  
Print  
Close

Complete the following fields under the Header 2 tab to submit a Nursing Home claim:

Field	Guidelines
Admission Date	Enter the date the member was admitted into your facility in MM/DD/CCYY format. Required only if the patient was admitted into your facility DURING the period you are billing for.
Admission Hour	If billing an admit claim, enter the admission hour.
Admission Type	If billing an admit claim, enter the admission type.
From DOS	Enter the claim coverage period from date.
To DOS	Enter the claim coverage period to date.
Admit Source	If billing an admit claim, enter the source of admission for this member.
Discharge Hour	If applicable, enter the hour of discharge from the facility.
Days Covered	Enter the total number of covered days.
Non-Covered Days	Leave blank, unless applicable.
Coinsurance	Leave blank, unless applicable.
Lifetime Reserve	Leave blank, unless applicable.



Field	Guidelines
Attending Provider ID/ NPI	If applicable, choose an attending physicians license number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Attending Provider ID/NPI field.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.

### 9.2.3 Header 3 Tab

Below is a sample electronic 837 Nursing Home form displaying the Header 3 tab.

The screenshot shows the '837 Institutional Nursing Home Claim' window with the 'Header 3' tab selected. The window title bar includes standard Windows controls. The form displays the following fields and controls:

- Total Charge:** .00
- OI Amount:** .00
- Billed Amount:** .00
- Services:** 1
- Header Tabs:** Header 1, Header 2, **Header 3**, Header 4, Service
- Diagnosis Codes:**
  - Primary:** A dropdown menu.
  - Admit:** A text input field.
  - Other:** Eight numbered text input fields (1-8).
- Patient Responsibility:** A text input field showing .00.
- Prior Auth/Referral Qualifier:** Two dropdown menus (1 and 2).
- Prior Auth/Referral Number:** Two text input fields (1 and 2).
- Member ID, Last Name, First Name, Billed Amount, Last Submit Dt, Status:** A row of six fields at the bottom.
- Buttons:** Add, Copy, Delete, Undo All, Save, Edit All, Find..., Print, Close.

Complete the following fields under the Header 3 tab to submit a Nursing Home claim:

Field	Guidelines
Diagnosis Code – Primary	Enter a valid primary diagnosis code. Code should be three to five digits with no decimal point.
Other	If applicable, enter a valid diagnosis code. If entered, code should be three to five digits with no decimal point.



Field	Guidelines
Admit	Enter a valid admittance diagnosis code. Code should be three to five digits with no decimal point.
Patient Responsibility	If applicable, enter the patient's monthly responsibility in DD.CC format.

#### 9.2.4 Header 4 Tab

Below is a sample 837 Nursing Home form displaying the Header 4 tab.

837 Institutional Nursing Home Claim

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 Header 2 Header 3 **Header 4** Service

**Value Codes/Amounts**

1		.00	2		.00	3		.00
4		.00	5		.00	6		.00
7		.00	8		.00	9		.00
10		.00	11		.00	12		.00

Other Insurance Indicator N Crossover Indicator N

Member ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
-----------	-----------	------------	---------------	----------------	--------

Add  
Copy  
Delete  
Undo All  
Save  
Edit All  
Find...  
Print  
Close

Complete the following fields under the Header 4 tab to submit a Nursing Home claim:

Field	Guidelines
Value Codes/Amounts	If applicable, enter the appropriate value code and the corresponding amount in DD.CC format.
Other Insurance Ind	Choose the best value to indicate whether or not the member has other insurance besides Georgia Medicaid.
Crossover Ind	Choose the best value to indicate if the claim is a crossover from Medicare.



## 9.2.5 OI (Other Insurance) Tab

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes' in Header 4. Below is a sample electronic 837 Nursing Home form displaying the OI (Other Insurance) tab.

The screenshot shows the '837 Institutional Nursing Home Claim' window with the 'OI' tab selected. The window title bar includes a home icon and standard window controls. The top status bar displays: Total Charge .00, OI Amount .00, Billed Amount .00, Services 1. The 'OI' tab is active, showing fields for Release of Medical Data, Benefits Assignment (Y), Claim Filing Ind Code, Adjustment Group Cd, Payer Responsibility, Reason Codes/Amts:1, and Paid Date/Amount (00/00/0000). Below these is the Policy Holder section with Group #, Group Name, Carrier Code, Last Name, and First Name. A table lists one service with Srv # 1, Carrier Code, Group #, Group Name, and Last Name. At the bottom is a table with columns: Member ID, Last Name, First Name, Billed Amount, Last Submit Dt, and Status. On the right side, there are buttons: Add, Copy, Delete, Undo All, Save, Edit All, Find..., Print, and Close.

Complete the following fields under the Other Insurance tab to submit a Nursing Home claim:

Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Claim Filing Ind Code	Choose the best value to indicate the category of the member's other insurance.
Adjustment Group Cd	Indicate the reason for any unpaid portion of the charges by the other insurance.
Payer Responsibility	Choose the best value to indicate the member's insurance coverage status to Medicaid. P = Primary; S = Secondary; T = Tertiary



Field	Guidelines
Reason Codes/Amts	If applicable, choose the appropriate code and enter the corresponding amount in DD.CC format.
Paid Date/Amount	If applicable, enter the date and the total amount the other insurance paid toward the claim in DD.CC format.
Policy Holder Group #	Choose the appropriate Policy Holder Group number from your Policy Holder list. If you have not added the group number to your list, double-click on this field to do so.
Group Name	This field will auto-populate based on the information chosen in the Group Number field.
Carrier Code	This field will auto-populate.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.

### 9.2.6 Crossover Tab

Completing the Crossover tab is required if the indicator in the *Crossover Ind* field was marked as 'Yes' in Header 4. If the claim is Medicare related, this tab allows you to enter the information based on the payment or non-payment made. Below is a sample 837 Nursing Home form displaying the Crossover tab.

The screenshot shows the '837 Institutional Nursing Home Claim' window with the 'Crossover' tab selected. The window has a title bar with standard Windows controls. Below the title bar, there are fields for 'Total Charge', 'OI Amount', 'Billed Amount', and 'Services'. The 'Crossover' tab is active, showing fields for 'Release of Medical Data', 'Benefits Assignment', and 'Claim Filing Ind Code'. Below these are fields for 'Paid Amount' and 'Paid Date'. A section titled 'Amounts' contains fields for 'Allowed', 'Deductible', 'Coinsurance', 'Copay', and 'Blood Deductible'. Below this is a 'Policy Holder' section with fields for 'Carrier Code', 'Last Name', and 'First Name'. At the bottom, there is a table with columns: 'Member ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'. On the right side of the window, there is a vertical stack of buttons: 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Edit All', 'Find...', 'Print', and 'Close'.



Complete the following fields under the Crossover tab to submit a Nursing Home claim:

Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the member, or authorized person, authorizing benefits to be assigned to the provider.
Claim Filing Ind Code	Choose the best value to indicate the category of the member's other insurance.
Paid Amount	Enter the total amount Medicare paid toward the claim. Enter in DD.CC format.
Paid Date	Enter the date Medicare paid the claim in MM/DD/CCYY format.
Amounts Allowed	Enter the Medicare allowed amount.
Deductible	If applicable, enter the deductible related to the claim.
Coinsurance	If applicable, enter the coinsurance related to the claim.
Policy Holder Carrier Code	Choose the appropriate code from drop-down menu. If you have not added the Carrier Code to your list, double-click on this field to do so.
Last Name	This field will auto-populate based on the information chosen in the Carrier Code field.
First Name	This field will auto-populate.



## 9.2.7 Service Tab

Below is a sample 837 Nursing Home form displaying the Service tab.

837 Institutional Nursing Home Claim

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 Header 2 Header 3 Header 4 OI Crossover Service

From DOS 00/00/0000 To DOS 00/00/0000 Revenue Code

Billed Amount .00 Units .00 Basis of Measurement UN

Unit Rate .00 Non-Covered Charge .00

RX Ind N

Add Srv Copy Srv Delete Srv

Srv #	From DOS	To DOS	Revenue Code	Units	Billed Amount
1	00/00/0000	00/00/0000		.00	.00

Member ID Last Name First Name Billed Amount Last Submit Dt Status

Find... Print Close

Complete the following fields under the Service tab to submit a Nursing Home claim:

Field	Guidelines
From DOS	Enter the start date of the service billed in a MM/DD/CCYY format.
To DOS	Enter the stop date of the service billed in a MM/DD/CCYY format.
Revenue Code	Enter Revenue Code '0101' for nursing home days. If you would like to add Revenue Codes to your list, double-click on this field to do so.
Billed Amount	Enter the amount billed for the service. Enter in DD.CC format.
Units	Enter the number of days billed.
Basis of Measurement	Choose the best value to indicate measurement. Ex: DA for days
Unit Rate	Enter the provider per diem rate in DDD.CC format.
Non-Covered Charge	Enter any charges that are non-covered. This field is optional.
Rx Indicator	If the procedure you are billing requires a NDC (National Drug Code) according to Georgia Medicaid Policy, please choose yes and complete the



Field	Guidelines
	RX tab before adding any additional line items.

After completing all necessary fields under the Service tab, review your claim and press Save.

#### 9.2.7.1 Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

#### **Note on bed holds:**

0101	LTC DAYS (ALL INCLUSIVE RATE R&B)
0182	HOME LEAVE DAYS
0185	HOSPITAL LEAVE DAYS

If Bed Hold Days apply, a second line of service is needed. Enter 0182 as the revenue code for days spent at home or 0185 for days spent in the hospital. See example below:

Line 1: Date of Service: 07/01/2007-07/31/2007 Revenue Code: 0101 Units: 31 Line 2: Date of Service: 07/15/2007-07/17/2007 Revenue Code: 0185 Units: 2

**Note:** Providers are now required to indicate which dates of service qualify for Bed Hold, along with the amount of days and the type of Bed Hold.



## 9.2.8 RX Tab

837 Institutional Nursing Home Claim

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 Header 2 Header 3 Header 4 OI Crossover Service **RX**

**Pharmaceutical**

NDC

Quantity 0.000 Unit Price .00 Unit of Measurement

**Add RX** **Copy RX** **Delete RX**

RX #	NDC	Quantity	Unit of Measurement	Unit Price
1		0.000		.00

**Member ID** **Last Name** **First Name** **Billed Amount** **Last Submit Dt** **Status**

**Add** **Copy** **Delete** **Undo All** **Save** **Edit All** **Find...** **Print** **Close**

Field	Guidelines
Pharmaceutical NDC	Choose an NDC code from your NDC list to indicate which applies to this service. If you have not added the required NDC to your list, double-click on this field to do so.
Quantity	Enter the quantity of the drug indicated by the NDC that is being billed.
Unit Price	Enter the cost per unit of the NDC indicated that is billed to the patient. Leave as ".00" if the price per unit is unknown.
Unit of Measurement	Select the unit that was used for measuring the quantity of the NDC.

## 9.2.8.1 Adding, Deleting, or Copying a Prescription (RX)

Use the buttons to the left of the form to add, delete, or copy an RX. Once you copy an RX, you can modify it as necessary.

After completing all necessary fields and reviewing entered data for accuracy, **press Save** to add your claim to the Claim List.



#### 9.2.8.2 To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

1. Key over incorrect data on the claim form. ***You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete).*** Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
2. Press 'Copy' to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different members). Modify the new record accordingly. Save the new record.
3. Press 'Delete' to delete an unwanted record.

#### 9.2.8.3 Submitting Voids/Adjustments to a Paid Claim (if claim you wish to Void/Adjust is in your claim list)

1. Find the Claim you wish to Void/Adjust from the Institutional Nursing Home List. Press Copy.
2. In the Type of Bill field, select the appropriate code to inform Medicaid if the request is an Adjustment/Replacement or a Void. Select the appropriate Type of Bill ending in a **'7'** for an adjustment or an **'8'** for a void.

#### **CLAIM FREQUENCY:**

- a. 7 - (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously created claim.
  - b. 8 - (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.
3. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim was accepted and paid. This information can be located on your *Remittance Advice*.
    - a. If the value '7' was chosen, make any necessary corrections/adjustments to the current claim.
    - b. If the value '8' was chosen, please continue with Step 4.
  4. Press 'Save' to save your claim, and follow Section 9.3 Submitting Claims through the Web Server.

**Note:** To adjust or void a paid claim, wait until you have received your Remittance Advice listing the paid claim's ICN/TCN.



#### 9.2.8.4 Submitting Voids/Adjustments to a Paid Claim (if claim you wish to Void/Adjust is NOT in your claim list)

1. Enter your claim as you normally would, completing all necessary fields.
2. In the Type of Bill field, select the appropriate code to inform Medicaid if the request is an Adjustment/Replacement or a Void. Select the appropriate Type of Bill ending in a **'7'** for an adjustment or an **'8'** for a void.

#### **CLAIM FREQUENCY:**

- a. 7 - (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously created claim.
  - b. 8 - (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.
3. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim was accepted and paid. This information can be located on your *Remittance Advice*.
    - a. If the value '7' was chosen, make any necessary corrections/adjustments to the current claim.
    - b. If the value '8' was chosen, please continue with Step 4.
  4. Press 'Save' to save your claim, and follow Section 9.3 Submitting Claims through the Web Server.

**Note:** To adjust or void a paid claim, wait until you have received your Remittance Advice listing the paid claim's ICN/TCN.



### 9.3 Submitting Claims through the Web Server

Select Communication >> Submission to display the Batch Submission window, pictured below:

The screenshot shows the 'Batch Submission' window with the following elements:

- Title Bar:** hp Batch Submission
- Tab:** Submission
- Method:** Web Server (dropdown menu)
- Buttons:** Select All, Deselect All (for both Files To Send and Files To Receive)
- Files To Send List:**
  - 837 Dental
  - 837 Institutional Inpatient
  - 837 Institutional Nursing Home
  - 837 Institutional Outpatient
  - 837 Professional
- Files To Receive List:**
  - 824 Claim Acknowledgement(s)
- Right Side Buttons:** Submit, Close

1. Determine which files you want to send from the Files to Send list. Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.
2. Determine which files you want to receive from the Files to Receive list. Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.
3. Press 'Submit' to send and/or receive files. Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.
4. After submission, follow Steps 1-3 to receive the response from the Web Server.

Refer to "Receiving a Response" on page 133, for information about receiving responses, resubmitting files, and reviewing submission reports.

**Note:** When you submit batch transactions, you must wait a period of time (fifteen minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files, remember you are *receiving responses for any previous transmission where you have not already retrieved a response file, not the current transmission.*



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## 10 Receiving a Response

This chapter describes how to download a response, resubmit a batch, and understand the corresponding submission reports. .

This chapter contains the following sections:

1. Sending batch transactions to the Web Server
2. Downloading responses from the Web Server
3. Viewing batch responses
4. Resubmitting batches

### 10.1 Sending Batch Transactions to the Web Server

*Provider Electronic Solutions* enables you to submit batch (groups of one or more records) transactions to the HP Enterprise Services Web Server for all claim types, including claim adjustments and voids.

**Note:** You may download (send) and upload (receive) batches as often as you like; however, if you are using a dial-up modem, there is a long distance charge associated with each transmission if you are located outside the Atlanta calling area.

Records that are ready for batch submission have a status of 'R'. The status displays on the list field at the bottom of the claim form. Once you have added and saved all the records you want to include in your batch, perform the following steps to submit a batch transmission:

Select Communication>>Submission to display the Batch Submission window, pictured below:



hp Batch Submission

Submission

Method: Web Server

Select All Deselect All

**Files To Send**

- 837 Dental
- 837 Institutional Inpatient
- 837 Institutional Nursing Home
- 837 Institutional Outpatient
- 837 Professional

Select All Deselect All

**Files To Receive**

- 824 Claim Acknowledgement(s)

Submit

Close

1. Determine which files you want to send from the 'Files to Send' list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

2. Determine the files you want to receive from the Files to Receive list.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Follow Steps 1-2 to receive the response from the Web Server.

**Note:** When you submit batch transactions, you must wait a period of time (fifteen minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files remember you are *receiving responses for any previous transmission where you have not already retrieved a response file, not the current transmission*. Claims rejected will not show up on your Remittance Advice.



## 10.2 Downloading Responses from the Web Server

You can download responses from the Web server in as little as fifteen minutes to one hour after submission.

To download a response, follow the instructions provided in Section 10.1, Sending Batch Transactions to the Web Server. The system displays a 'Submission Successful' message when it successfully connects with the Web Server. This does not mean that your response file has been downloaded.

To determine whether a response has been downloaded, review the file name in the Communication Log or the Verification Log and search for that file name in the Response Log. You can also watch the system as it attempts to download a response. If *Provider Electronic Solutions* locates your response file on the Web Server, it will indicate the number of files downloaded in the lower left hand corner of your screen.

View the response by selecting the Communications>>View Batch Response menu option.

## 10.3 Viewing Responses

This section describes viewing the batch response, claim submission response, Report/997s, and communication log screens.

### 10.3.1 View Batch Response

This option enables the user to view a 997 response. The report shows whether or not claims were accepted or rejected as well as the batch identification number.

The 997-response informs the user if the claim was successfully uploaded to the Web server and if the claim was HIPAA-compliant. *Provider Electronic Solutions* will not allow a user to send a Non-HIPAA-compliant transaction, therefore all 997 responses should be sent back with an AK5 indicating the file was HIPAA-compliant and will cycle to Medicaid for processing.

When reviewing your 997 if the AK9 indicates an 'R', you can contact the EDI Helpdesk at 866-261-8785, for assistance.

### 10.3.2 View Communication Log

This option enables the user to view a log of each transmission that occurs between *Provider Electronic Solutions* and the HP Enterprise Services system (interactive submission) or Web Server (batch submission and software upgrades). Each occurrence is assigned a file name. Users scroll down the list of file names located at the top of the Communication Log window and click on a row to access the log associated with the file name.



## 10.4 Resubmitting Batches

Select Communication>>Resubmission to resubmit entire batches, resubmit records within batches, or to copy batches or records within batches for modification and resubmission. The Batch Resubmission window displays.

Users select from a list of previously submitted batches. The user highlights a particular batch to display all records stored within the batch. The user may perform any of the following:

1. Click 'Select All' to select all records within a batch for resubmission, then press the 'Resubmit' button to resubmit the batch;
2. Click on one of the records for the batch displayed and press 'Resubmit';
3. Select the 'Copy' button to copy the entire batch
4. Click on one of the records for the batch displayed and press 'Copy.'

To modify copied records, access the corresponding claim, and select the copied record from the list that displays at the bottom of the form. Modify and save the record, then submit according to the instructions in Section 10.1, Sending Batch Transactions to the Web Server.



## 11 Producing Reports

This chapter describes how to select and produce detail, summary, and list reports. It contains the following sections:

1. Detail and Summary Reports
2. Other Reports

### 11.1 Detail and Summary Reports

*Provider Electronic Solutions* enables you to print detail and summary reports for your claims.

Selecting Reports>>Detail Forms enables you to produce a detail report that shows the claim in its entirety.

Selecting Reports>>Summary Forms enables you to produce summary reports such as the basic member information, billed amount, the date the claim was last submitted, claim status and the service (claim) lines.

When you select either the detail or summary menu options, you must also select a form. The Detail or Summary Reports window displays accordingly. To customize the report, enter information into at least one of the following fields and press 'Enter':

1. Batch Number
2. Member ID
3. Form Status
4. Submit Date

The system displays a print preview of the report and populates the Records Selected field with the number of records included on the report. Send the report to your printer as required.

### 11.2 Generating a Detail Form Report

You may select any option available on the Detail Form screen. Choosing this option will allow you to generate a detailed report for any claim type, eligibility request, claim status, or prior authorization request. Follow the step-by-step procedures below to complete this process:

Click on Reports >> Detail Forms >> and choose the desired report. The available list includes:

1. 837 Dental
2. 837 Institutional Inpatient



3. 837 Institutional Nursing Home
4. 837 Institutional Outpatient
5. 837 Professional

**Note:** Creating these detailed reports will not include the responses created upon transmission. The only claim status you will receive on this report is the status of the claim within the Provider Electronic Solutions software. The status indicators include F (Finished/or successfully sent to Medicaid), A (Archived), I (Incomplete Transmission), and R (Ready to send).

These reports are to be used as a form of proof of filing, claim entry, and internal usage.

Choose one of the search criteria's to generate your report. A listing of each option is defined below:

Search Criteria Option	Usage
Batch Number	This number creates a report according to the information entered and submitted on one particular batch transmission. You can locate the Batch Numbers within the Communication>>Resubmission screen.
Member ID	To limit the detail report to a request for a certain member, enter the appropriate twelve-digit member ID in this field
Form Status	To create a detailed report according to a certain form status, select the appropriate form status from this field's drop-down list.
Submit Date	To create a detailed report, according to the date of submission, enter the appropriate date in MM/DD/CCYY format.

1. Click 'OK' after entering or choosing a value in one of the option screens as listed in Step 1.
2. Click on 'Print' if you wish to print a copy of the report listed on your screen.
3. Click on 'Close' to exit the Detail Report screen.



### 11.3 Generating a Summary Report

You may select any option available on the Summary Form screen. Choosing this option will allow you to generate a basic report for any claim type. Follow the step-by-step procedures below to complete this process:

Click on Reports >> Summary Forms >> and choose the desired report. The available list includes:

1. 837 Dental
2. 837 Institutional Inpatient
3. 837 Institutional Nursing Home
4. 837 Institutional Outpatient
5. 837 Professional

**Note:** Creating these summary reports will not include the responses created upon transmission.

1. Choose one of the search criteria's to generate your report. A listing of each option is defined below:

Search Criteria Option	Usage
Batch Number	This number creates a report according to the information entered and submitted on one particular batch transmission. You can locate the Batch Numbers within the Communication>>Resubmission screen.
Member ID	To limit the detail report to request for a certain member, enter the appropriate 12-digit member ID in this field
Form Status	To create a detailed report according to a certain form status, select the appropriate form status from this field's drop-down list.
Submit Date	To create a detailed report, according to the date of submission, enter the appropriate date in MM/DD/CCYY format.

2. Click OK after entering or choosing a value in one of the option screens as listed in Step 1.
3. Click on 'Print' if you wish to print a copy of the report listed on your screen.
4. Click on 'Close' to exit the Summary Report screen.

### 11.4 Other Reports

*Provider Electronic Solutions* enables you to print reports of all you have stored in your list screens. Select the Reports menu option, then choose from the following:



Detail Forms	Patient Status
Summary Forms	Place of Service
Provider	Policy Holder
Member	Procedure/HCPCS
Other Provider	Revenue
Taxonomy	Type Of Bill
Admit Source	Value Code
Admission Type	Modifier
Carrier	NDC
Condition Code	Occurrence
Diagnosis	OI (Other Insurance) Reason

**Note:** You may print any of these reports as you so choose. Please be advised that the information displayed within the report is based on your List screens. The Place Of Service, OI (Other Insurance) Reason, Patient Status, and Type of Bill lists have already been populated by HP Enterprise Services. The other list screens are only populated if you choose to enter and save such information.



## 12 The Web Server

This chapter provides instructions on what steps to take when connecting to the Web Server to update your passwords according to the logon IDs provided to you by the EDI Helpdesk.

Users can access the Web Server with the following methods:

1. Connecting through an ISP; or
2. Connecting through the RAS (an option provided by the *Provider Electronic Solutions* software).

### 12.1 Updating and Maintaining your Web Server Password

Along with your Provider Electronic Solutions software, you should have received an e-mail with your initial logon ID and a link to select your password and security question and answer. Your password will need to be updated before a transmission can be attempted through the software. As a security measure, this password will need to be updated every sixty days. Follow the steps below to complete this process according to the method you use to connect to the Internet.

#### 12.1.1 Connecting through an ISP

This section will inform you how to logon to the Web Server through an ISP, such as AOL, NetZero, Cox, and so on.

1. Open your ISP application and connect to the Internet accordingly.
2. Once properly logged on to the World Wide Web, type in the following URL:  
[www.mmis.georgia.gov](http://www.mmis.georgia.gov).
3. Continue to Step 3 in section 12.1. Updating your Web Portal Password below for further instructions.

#### 12.1.2 Connecting through RAS

Connecting through RAS is an option created by the *Provider Electronic Solutions* software. This section will inform you how to logon to the Web Server through RAS if you do not have an ISP.

This method requires you to have Internet Explorer version 5.5 or Netscape Navigator version 6.1 and a dial-up modem. If you do not have one or the other, you will need to contact your computer administrator to have it set up for you.

**Note:** Before beginning this process, you should have followed the instructions outlined in section 2.4. Batch Tab. If you have not, please refer to the instructions to set up your connection method through 'modem'. You will need to follow the instructions described in the 'Install RAS' and the 'Dialup Network' fields.

1. Open your GA RAS connection. To do so, click on Start >> Settings >> Control Panel >> 'Network and Dial-Up Connections' and open the 'GA RAS' option.



2. Once opened, a screen should appear as shown below: (If you have completed these steps you may continue to **Step 3** in section 12.1, Updating your Web Portal Password below for further instructions.)



The image shows a Windows-style dialog box titled "Connect GARAS". It features a blue header bar with a question mark icon and a close button. The main area has a blue background with a graphic of two laptops and a globe. Below the graphic are two text input fields: "User name:" with the text "Medicaid" and "Password:" with masked characters "\*\*\*\*\*". A checkbox labeled "Save this user name and password for the following users:" is checked. Below it are two radio buttons: "Me only" (selected) and "Anyone who uses this computer". At the bottom, there is a "Dial:" label and a text box containing the number "18778484989". Four buttons are at the very bottom: "Dial", "Cancel", "Properties", and "Help".

**Note:** Do not adjust the User Name or Password. The default information should remain keyed within these fields. If you have erased either, contact the EDI Helpdesk at 866-261-8785 for the correct password and/or User Name.




3. Click on 'Properties' and click on the 'Networking' tab. A sample screen is pictured below:




4. Make sure the Internet Protocol (TCP/IP) option is highlighted and click on 'Properties'.
5. Make sure the option for 'Use the following DNS server addresses' has been chosen. In the Preferred DNS server field type in 10, 1, 1, 17. A sample screen is pictured below:



6. Click on 'OK' to save your changes. Click on 'OK' to exit the Networking tab.
7. Click on 'DIAL' to continue to connect through RAS. This will begin the dial-up process according to the number you entered in the Web tab. Refer to section 2.4. Batch Tab.
8. Once connected you may open your Internet Explorer or Netscape navigator browser.
9. The options for accessing your Internet Explorer browser are described below:

- a.  Go to your Internet Explorer icon located on your desktop.
- b. Click on Start >> Programs >> Internet Explorer

10. The options for accessing your Netscape browser are described below:

- a.  Go to your Netscape Navigator icon located on your desktop.
- b. Click on Start >> Programs >> Netscape Navigator

**Note:** If you have a default home page within your IE or Netscape browser a message may appear that it was unable to connect. Ignore this message and in your address bar type in the following URL: [www.mmis.georgia.gov](http://www.mmis.georgia.gov).

11. Continue to **Step 3** in section 12.1. Updating your Web Portal Password below for further instructions.



### 12.1.3 Updating your Web Portal Password

This section will inform you how to logon to the Web Server through an ISP, such as AOL, NetZero, Cox, and so on.

1. Open your ISP and connect to the Internet accordingly.
2. Once properly logged on to the World Wide Web type in the following address:  
www.mmis.georgia.gov
3. Enter your username and password.
4. Press the 'Sign in' button to continue.
5. On the "Georgia Medicaid Home" page, click on the link Account Management.
6. On the "Account Home" page, click the button [Change Password].
7. The "Change Password" page is now displayed.
8. Enter your old password.
9. Enter your new password. Make sure your new password conforms to the format indicated on the screen.
10. Re-enter your new password into the "Password (verify)" text box.
11. Click the button 'Change Password' to save your changes or click the button [Cancel] to abort the operation.

## 12.2 Other Maintenance Options

The Tools menu options enable users to archive data, recover the database, download upgrades, and set up options. This section describes other maintenance options such as archiving and database recovery.

### 12.2.1 Archiving

Archiving is designed to make management of forms easier and to keep the space on your hard drive used by the *Provider Electronic Solutions* application to a minimum.

One of the options available under Tools>>Archive>>Create is the setting that controls how many days of forms you wish to keep online on your PC. You may select whatever setting best suits your needs. The standard setting is thirty (30) days. This means that when you select Tools>>Archive>>Create Archive from the menu bar, you will archive a copy of any form which was submitted more than thirty (30) days ago. The form is copied to a compressed file and then deleted from your Provider Electronic Solutions database. Forms submitted within the past thirty days are still accessible through the Provider Electronic Solutions database.



You can store the compressed file on a diskette or leave it on your hard drive. Forms that are ready to be submitted (that have a status of 'R') are not archived, but remain on your online database until you have submitted or deleted them. Forms that are incomplete (that have a status of 'I') and are older than the archive data are removed during the archive process and are not saved on the archived file.

### 12.2.2 Create Archive

This section describes how to create an archive and how to restore archived files.

**Note:** If running *Provider Electronic Solutions* on a network, other users must exit the application (must not be viewing, adding, or modifying any forms or lists) before you create an archive. The user creating the archive should have the only open copy of the software while the archive process runs.

To create an archive, select Tools>>Archive>>Create from the menu bar. After verifying that all forms and lists are closed, click OK to proceed. The Archive Forms window displays:



Using this window, you can:

1. Select all the form types to archive by clicking on the 'Select All' button (click on 'Deselect All' to deselect). You may also select specific form types to archive by clicking on the form type.
2. Change the default directory and the name of the file to archive by typing the path name in the Archive file field, or by clicking on the Browse button.
3. Change the number of days used to archive the forms. (This change applies to the current session only. Select Tools>>Options>>Retention Tab to change the number of retention days for all future sessions.)
4. Select 'OK' to archive the selected forms. Select 'Cancel' to exit the archive function.



Once you select 'OK', the system archives the forms that match the selection criteria. *Provider Electronic Solutions* displays a confirmation message upon completion. Click 'OK' to exit the Create Archive process.

**Note:** You can use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.

### 12.2.3 Restore Archive

The Restore Archive process enables users to recall forms from an archive file and put them back into the online database. For instance, if you elect to archive to diskette claims more than thirty days old, Restore Archive enables you to return them to the list that displays at the bottom of the *Provider Electronic Solutions* claim form.

Restored claims display with a status of 'A'. You cannot change information on these claim forms; however, you can use the restored forms to:

1. Review them to confirm information
2. Print them in a report
3. Copy them to create a new claim form

Perform the following to restore archived forms:

1. Select Tools>>Archive>>Restore from the menu line. The Restore Forms window displays:

hp Restore Forms

Type the archive file name you want to use to restore the forms.

Browse...

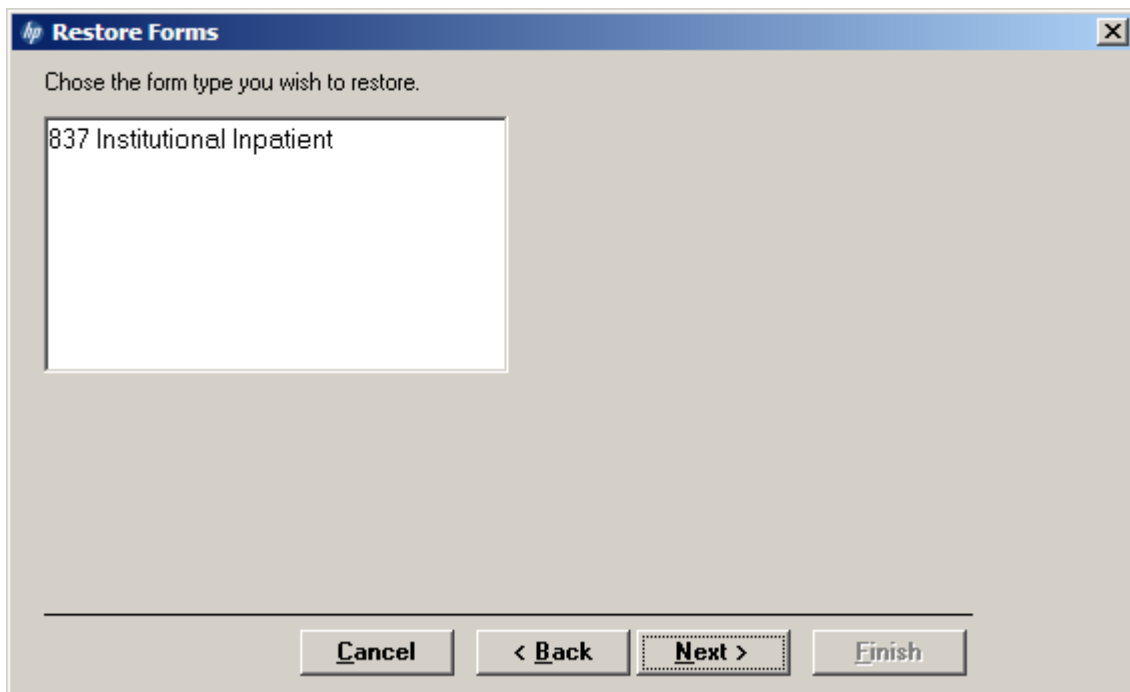
Cancel < Back Next > Finish



2. Type in the path and file name of the file to restore and click the 'Next' button, or click on the 'Browse' button to search for the path and file name. The following window displays:



3. Select the file and path name and click 'Open' button. Click 'Next' to display the Restore Forms window, pictured below:



4. Determine which form type(s) you want to restore. To select multiple form types, follow the procedures indicated in the second note under the Create Archive section. Click the 'Next' button to proceed.



5. *Provider Electronic Solutions* displays a message if it does not locate any forms matching the selection criteria for the file and path name you selected. When this occurs, you may select 'OK' to select another form type or 'Back' to go back and change the archive path and file name.
6. When *Provider Electronic Solutions* finds forms that match the selection criteria, the following displays:

Member ID	Last Name	First Name	Billed Amount	Last Submit	Form type
728343765426	CLIENT	TEST	432.00		

7. Select the restore option you want (all at once or only selected forms). To select multiple forms, follow the procedures indicated in the second note under the Create Archive section. The window displays forms by Insured ID (Member ID), Last Name, First Name, Billed Amt, and Last Submit Dt. Click the Finish button to proceed.
8. *Provider Electronic Solutions* displays a message upon successful restoration of the archived forms. Click 'OK' to exit the Restore Archive process.

## 12.3 Database Recovery

If you need the *Provider Electronic Solutions* Database Recovery option, it is designed to help you work with the EDI services team personnel to fix problems.

### 12.3.1 Repair Database

Repair will attempt to validate all system tables and all indexes. Generally, this feature is helpful when you are having trouble accessing your data. The EDI services team staff will let you know when this is necessary. You may use this feature any time you feel that it would be helpful. Compacting is recommended after the Repair.



### 12.3.2 Compact Database

Compact is used to make the database files smaller and better organized. When you delete a form, empty space is created in the database where that form used to be. Compact releases all the empty space so that it is available for you to use again.

### 12.3.3 Unlock Database

Sometimes errors will cause your Provider Electronic Solutions database to lock. The database may lock when you are submitting forms, archiving forms, restoring forms, and possibly when you are adding or editing forms. Use the Unlock feature to unlock the database tables.